

M April 1953

Medical Economics

How You'll Fare Under
The New Doctor Draft



Also in this issue:

A Yardstick for Setting Fees

How to Borrow Money Economically

Doctors May Scrap Service-Type Plan

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Medical Economics

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PRICE: 50 cents a copy, \$5 a year (Canada and foreign, \$6). Acceptance authorized under Section 34.64 PL&R. **CIRCULATION:** 134,000 physicians and residents. **PICTURE CREDITS** (left to right, top to bottom): cover, 121, William Crawford; 6-7, Ralph Morgan; 8, 155, Wide World; 9, Vincent A. Finnigan; 101, Patry & Carr; 106-109, Forde; 113, Hal Matson, Colbourn; 116-117, Knopf-Pix; 122-125, U. S. Army; 130-131, Hopwood; 133, Wide World; 136, Detroit Times; 139-151, Al Kaufman; 211, Delma; 218-219, Robert Lund; 251, Carlan; 255, Louisville Courier-Journal; 267, Voorhis.

Panorama

Law tyros quiz doctors

- Labor gets front man • TB deaths plummet • Are you newsworthy? • M.D.'s retreat on fees • A.M.A. says yes to Ike • Letter details fee fix • April-June doctor draft quota cut

Law Tyros Quiz Doctors

There's an ambitious effort underway to dissect the American medical profession and see what makes it tick. Key sources of information in the research project are the A.M.A. and the various state and territorial societies; they've been asked to answer an 83-question form that runs the gamut of topics from membership qualifications to political activities.

Who's asking all these questions? Not doctors, but students of law—the editors of the Yale Law Journal. They hope to learn, among other things:

¶ How much money state medical societies collect and spend.

¶ What the societies do about expelling undesirables.

¶ Where the societies stand on fee splitting.

¶ Who represents the societies on legislative matters.

¶ How the societies handle health insurance questions.

The Yale students figure that

they'll be ready to report their findings in the fall—making this a lengthy project. The questionnaires were dropped into the mail in mid-January, and last month one-third had been returned—all filled out. So the going was slow, but one thing heartened the student investigators: There had been no refusals.

Labor Gets Front Man

Big Labor has a new health scheme. And it's got someone to sell the scheme—someone plucked right from the heart of Big Business.

The aim is to recruit doctors for a nationwide network of union-sponsored group health plans. The man who will do the recruiting is Dr. William A. Sawyer of Rochester, N.Y., medical director of Eastman Kodak for more than thirty years. His employers: the International Association of Machinists (A.F.L.), one of the largest unions in the U.S.

A major part of Dr. Sawyer's work, as Al Hayes, his new boss and I.A.M. president, puts it, will be "to

present the union's program for helping to solve the high cost of doctor bills... in testimony before Congressional committees, state legislatures, and the medical profession."

TB Deaths Plummet

Flashiest of medicine's victories last year was scored over tuberculosis. The death rate for the disease, says Metropolitan Life, dropped not just a percentage point or so, or a fraction of a point, as with most diseases, but a striking 25 per cent—in just twelve months.

The opposite side of the coin is less gratifying: While doctors of medicine were helping to bring TB down this way, drivers of automobiles, and others, were pushing the country's accident rate up—by 9 per cent, the year-end figures showed.

Are You Newsworthy?

A typical editor has told publicity-shy physicians when they can expect their names to make news. "If the *doctor* is the story," says Stan Witwer, city editor of the St. Petersburg (Fla.) Times, "then we use his name. If the *patient* is the news, the doctor needn't be named."

Pin-pointing his view, Witwer explains that a doctor's name is vital to a news item when, for example, he contributes something to medical research. But if the physician simply does "what any doctor would or could do," he needn't be identified.

This isn't always an easy distinction for a lay editor to make, he points out, because medical men "have clothed their activities in so much mystery." Practices that are commonplace to a doctor often appear unusual to the layman.

Witwer's prescription: Let medical societies appoint doctors to advise newsmen on what's unusual and what isn't.

Military Medical Boss

The lettering on his door would read: Assistant Secretary of Defense for Health Affairs. He'd be boss-man over all military medical personnel, no matter what their branch of service.

At least that's the way the A.M.A. would like it. It reasons that if the drafting of physicians is to continue, there should be one key official in the Pentagon, responsible to the medical profession. And many rank-and-file practitioners seem to agree.

Prospects of such a post being created soon? Almost nil.

M.D.'s Retreat on Fees

Under implied pressure from the American College of Surgeons, Iowa physicians have revised their interpretation of the code of ethics as it applies to fee splitting. The main effect of the revision: stricter rules on the submission of joint bills.

Iowa's medical society was pressed into action by the refusal of the

PANORAMA

A.C.S. to extend membership to any additional Iowa surgeons as long as the society's old interpretation of the code was in force. That interpretation, dating back to February, 1952, had made it ethical for doctors to submit itemized joint bills to patients whose consent was "either expressed or implied."

Last December, the A.C.S. expressed its disapproval, and Iowa physicians decided some further

elaboration was in order. Their latest statement, prepared by Dr. Wendell L. Downing, a trustee of the state medical society, emphasizes that:

¶ When two or more doctors "actually and in person" treat one patient, they may submit a single bill. But the patient "or his legal representative" must be clearly told that the fee "is to be divided in proportion to the services rendered."

A.M.A. Says Yes to Ike

In Denver last December, the A.M.A. House of Delegates decided what it wanted most from the incoming Eisenhower Administration: a Department of Health, whose chief would be a member of Ike's Cabinet. Such a single-purpose department could coordinate the Government's many medical activities and benefit doctors and laymen alike.

But what of an even more sweeping reorganization: boosting the Federal Security Agency to Cabinet rank as a super-department, taking in welfare and education as well as health? No, thanks, said the House of Delegates (remembering its duels with Oscar Ewing); health, welfare, and education just don't mix. But the delegates did show their faith in the new President by saying they'd accept a layman as Secretary of Health.

In the first months of the new Ad-



ministration, though, it became abundantly clear that Eisenhower had no intention of splitting F.S.A. into its component parts and vaulting one, two, or all three of its major functions to full department status as separate

The joint bill must show "the names of the doctors and the respective amounts to be paid."

"Under no circumstances shall it be considered ethical for doctors to submit bills unless both have actually rendered service. Division of fees for referrals only shall be considered unethical."

The purpose of its interpretation of the code, says the society, "is to make plain to members . . . what is

ethical and legal in Iowa. It was not and is not now a subterfuge to cover up fee splitting or any other dishonest practice."

'Join the Regulars'

Congress could do a lot to reduce the need of a doctor draft—if it only would, charges Navy Surgeon General Lamont Pugh. The present draft, he emphasized at a Pentagon



units. Instead, the President showed interest in lifting the F.S.A. itself to Cabinet level. And a doctor in Congress, Rep. A. L. Miller (R., Neb.), introduced a bill to effect just such a reorganization.

As Miller explained his stand to MEDICAL ECONOMICS, "the A.M.A. simply has to realize it can't get everything it wants. It will have to settle for less."

Against that backdrop, last month, the A.M.A. took a rare step. It called its 185-man House of Delegates into special session in Washington. Purpose: to reappraise the situation.

And what was the upshot? The delegates voted unanimously to support Eisenhower's proposal for a new department. Key reason: A medical leader would be named special assistant to the Secretary, giving health a special role. But, the delegates said, if they spotted any socialist trend, they'd withdraw their support.

All in all, said many delegates last month, they'd made an intelligent compromise with reality. And they looked forward to a period of close cooperation between organized medicine and the Government.

PANORAMA

conference, is purely and simply "a continuation of an expedient."

Asked how a sound, long-term solution might be found, he replied with feeling:

"The armed forces should be made more attractive to physicians. Then more of them would accept regular commissions, and there'd be no need for a doctor draft."

The hitch, at present, as the Admiral sees it:

"There's too much uncertainty about Congressional policy" on pay and grades.

Letter Details Fee Fix

Dr. Paul R. Hawley, director of the American College of Surgeons, has found new ammunition in his battle against fee splitters and others of that ilk. His latest grenade: a letter from a young surgeon to his former teacher, spelling out the troubles he has faced in trying to get started in a small city. The teacher passed the letter along to Hawley, who covers up the surgeon's identity in quoting him as making these points:

¶ When the doctor applied for hospital staff privileges, he was shunted aside because of "one person who just doesn't want new surgeons."

¶ When the M.D. sought a charity clinic assignment, he was set back again because "some of the older men even have that tied up tight."

¶ When he asked certain col-

leagues to refer cases to him, they said "sure—for 50 per cent of the fee."

¶ When he met the head of a Texas medical group, he was offered this deal: "The doctors scheduled



April-June Doctor Draft Quota Cut

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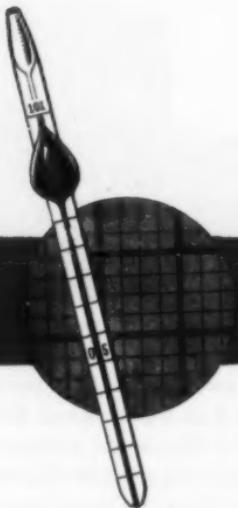
their own surgery and told the patient they would do the case; then I would do the surgery. They would collect the fee and give me half. It would amount to \$40,000 for me per year."

Comments Paul Hawley: The power of this "most eloquent indictment" is its clear portrayal of the "tragic disillusionment of a fine young surgeon before he has had his first patient."



Wagging a finger at Defense Secretary Charles E. Wilson, young Rep. Glenn Davis (R., Wis.) complains that the armed forces have more doctors than they need. Davis—in an open letter to Wilson—cites letters he has received from doctors, telling how they twiddle their thumbs in service camps. "It looks as if the armed services may be hoarding critical medical personnel," he charges. Wilson's reaction to the Davis blast? Nothing direct from the Pentagon, but President Eisenhower has supplied an apparent answer by announcing a cut in the current quarter's doctor draft quota by one-third. Instead of calling up 1,800 physicians in the April-June period, the services will try to get along with 1,200. Eisenhower—speaking at a news conference—mentioned the reduced quota as evidence that the services are trying to get by with fewer physicians. But there's no indication that the Pentagon's *long-range* draft policy has been changed.

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1. Isha, D.; Brit. M. J.: 2: 543-548, 1948.

2. Isha, D.; Brit. M. J.: 2: 601, 1950.

3. Hawking, F., and Lawrence, J. S. &
The Sulphonamides. New York, Grune
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1. Perry, W. F., and Boyd, E. M.: J. Pharmacol. & Exper. Therap. 73:85, 1941.

2. Ensrud, G. E., Jr.: Proceedings of the American



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You are invited to study the life-saving possibilities of the new leg-compression routine in your hospital. Write to Bauer & Black Research Laboratories, 309 W. Jackson Blvd., Chicago 6, Illinois, for an illustrated report on current pulmonary embolism studies.

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Deep calf veins of 50-year-old male who died of pulmonary emboli. Note beaded appearance of veins which were filled with ante-mortem clot. Note that parts of posterior tibial vein have greater diameter than the popliteal. Autopsy studies indicate that in the majority of cases, fatal pulmonary emboli begin as clots originating in deep veins of the leg.



Specimen photograph courtesy of Joseph R. Stann, M.D., Massachusetts Memorial Hospitals and Harvard University School of Medicine.

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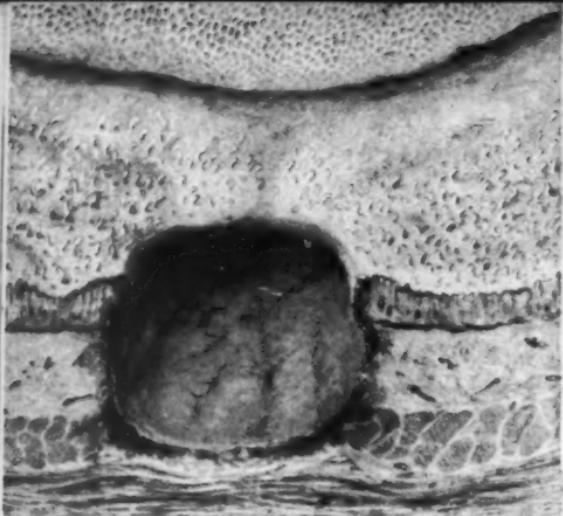
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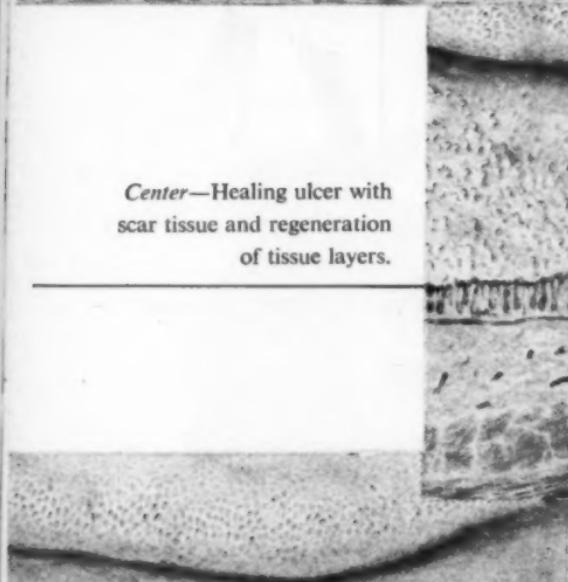
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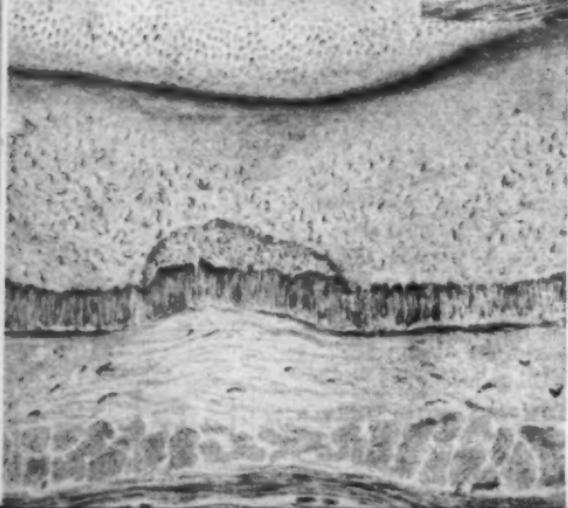
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Top—Section through duodenal bulb just distal to pylor through center of ulcer crater.



Center—Healing ulcer with scar tissue and regeneration of tissue layers.



Bottom—Healed ulcer with restoration of mucosa.

Searle Research Progress Report:

Continued investigational work has resulted in Pro-Banthine, a new anticholinergic drug with high potency, small dosage, minimal side effects, agreeable taste and convenient dosage schedule.

The new anticholinergic, Pro-Banthine* (brand of propantheline bromide) provides a powerful drug in the therapy of peptic ulcer, intestinal hypermotility and other conditions of parasympathotonia.

The high potency of Pro-Banthine permits its use in small dosage. With the suggested dosage of one tablet (15 mg.) with meals and two at bedtime there is little likelihood of untoward manifestations.

Pro-Banthine has a pronounced inhibiting action on stimuli at (a) the parasympathetic and sympathetic ganglia and (b) the effector organs of the parasympathetic system.

Pro-Banthine is produced for oral use in 15 mg. sugar-coated tablets.

SEARLE

Research in the Service of Medicine

*Trademark of G. D. Searle & Co.

TRUE HEMATOPOIETIC STIMULANT

Specific Bone Marrow Stimulation

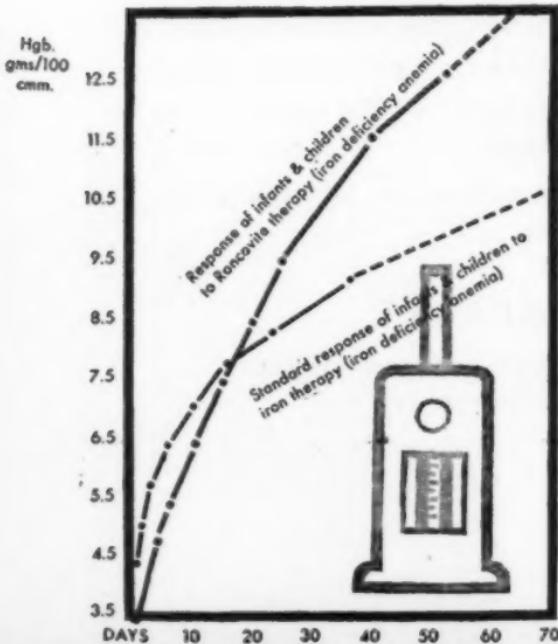
An entirely new approach to the successful treatment of human secondary anemia has been opened up with the introduction of the first true hematopoietic stimulant—Roncovite.

Roncovite offers, for the first time, the specific bone marrow erythropoietic action of cobalt—with adequate iron for the formation of hemoglobin.

In iron deficiency anemia where iron has been the standard treatment Roncovite produces a faster response, greatly superior erythropoiesis and up to fourfold increases in the utilization of iron.^{1, 2}

In the anemia accompanying infection or chronic inflammatory disease where iron is useless, Roncovite provides—in many cases—a striking and dramatic hematopoietic response.^{3, 4, 5, 6, 7}

The above clinical findings mean that Roncovite offers a significant advance in the treatment of all types of "secondary" anemia.



Comparison of the response of hypochromic anemic infants and children to Roncovite and to iron with Roncovite, iron utilization was so efficient that 58% of the ingested iron was converted to hemoglobin—as compared to the usual average of 15% utilization from ferrous sulfate.—
Standard response chart Joseph H. J. Pediat. 49:246 (1951).

RONCOVITE*

RONCOVITE—PIONEERED BY LLOYD RESEARCH

Tablets—each enteric coated, red tablet contains:

Cobalt chloride (Cobalt as Co....3.7 mg.).....15 mg.

Ferrous sulfate, exsiccated (Iron as Fe....60 mg.).....0.2 Gm.

Average adult dosage—1 tablet after each meal and at bedtime.

Supplied in bottles of 100 tablets.

Drops—each 0.6 cc. contains:

Cobalt chloride (Cobalt...9.9 mg.).....40 mg.

Ferrous sulfate (Iron...15.1 mg.).....75 mg.

Average dose—0.6 cc. (10 minims) diluted with water, milk, fruit or vegetable juice once daily to infants and children.

Supplied in bottles of 15 cc. with calibrated dropper.

1. Wolff, H.: Med. Monatsschr. 5:239 (1951); (2) Rohn, R.J., and Bond, W.H.: to be published; (3) Bork, W., et al: New England J.M. 240:754 (May) 1949; (4) Robinson, J.C., et al: New England J.M. 240:749 (May) 1949; (5) Weissbecker, W., and Maurer, R.: Klin. Woch. 24:855 (1947); (6) Wolff, H., and Barthel, S.: Munch. M. Woch. 93:467 (1951); (7) Gardner, F.H.: J. Lab. & Clin. M. 41:56 (Jan.) 1953.

*The pioneer cobalt product; a product of Lloyd Research.

Total
RBC increment
in thousands
per cmm.

3,600
3,200
2,800
2,400
2,000
1,600
1,200
800
400

RONCOVITE

Iron therapy

Time in days 5 10 15 20 25 30 35

Comparison of the average erythrocyte response of iron-deficiency anemic children to Roncovite and to iron therapy.—Computation—Method of Schioldt: Am. J. Med. Sci. 193:313 (1937).

LLOYD BROTHERS, Inc., Cincinnati 3, Ohio

In the Interest of Medicine Since 1870

Adjunct to CERVICOVAGINAL SURGERY:

FURACIN

For shorter, smoother convalescence:

FURACIN VAGINAL SUPPOSITORIES



1. Eroded cervix of multiparous patient with malodorous leukorrhea.¹



2. Same cervix immediately following radial electrocauterization.



3. Two weeks later, Furacin Vaginal Suppositories being used twice daily.



4. Complete healing 3 weeks later. Slough and discharge were minimal.

In cervical cauterization or conization, and hysterectomy, the pre- and postoperative use of Furacin Vaginal Suppositories can decrease discharge, malodor, discomfort, and facilitate healing. This is attained by control of surface bacterial infections in this contaminated field.

Some advantages of Furacin:

- Bactericidal to the majority of pathogens of surface infections
- Effective in blood, pus and serum
- No interference with healing or phagocytosis

References: 1. Schwartz, J.: *Furacin Vaginal Suppositories in Pre- and Postoperative Treatment of Cervix and Vagina*, Am. J. Obst. and Gynee. 63:579 1952 • 2. Doyle, J. C.: *Vaginal Infections and Their Management*, Urol. & Cutan. Rev. 55:618, 1961.

Formula: Furacin Vaginal Suppositories contain Furacin 0.2%® brand of nitrofurazone N.R., dissolved in a self-emulsifying, water-miscible base composed of glyceryl laurate 10% and synthetic wax. Box of 12.

Literature on request



EATON & Inc.
NORWICH NEW YORK



OTHER DOSAGE FORMS OF FURACIN INCLUDE:

FURACIN SOLUBLE POWDER

FURACIN NASAL

FURACIN OPHTHALMIC

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Sidelights

Yardstick for fees • Why

patients kick • Move to the country • Lesson from chiros

Yardstick for Fees

Twenty years ago, this magazine published a schedule of average fees. It was a composite of the schedules then being used by a hundred medical societies. The listed fees included \$1 for telephone advice, \$4 for a night call, \$49 for an instrumental delivery, \$117 for an appendectomy, \$218 for a gastroenterostomy. A good many doctors throughout the country used this list as a yardstick.

Since that time, fee schedules have multiplied. So have their dollar differences. As a result, no national compilation of this sort would be of much help to today's doctor.

But though dollar values vary, the relationships between fees shouldn't. Suppose a cross-section of doctors agree that an appendectomy is worth twice what a child's T. & A. is worth. Doesn't this provide a fee ratio that doctors everywhere can use?

In the belief that it does, Dr. William H. Horton of the Connecticut Medical Service has made an interesting pilot study along these lines. His findings are reported elsewhere in this issue. They foreshad-

ow a new type of fee index—a type that MEDICAL ECONOMICS has been researching nationally and will report on in greater detail later.

Why Patients Kick

An accountant we know helps manage the business affairs of several dozen doctors. In the course of collecting their bills, he noticed recently that the surgeon who charged the lowest fees habitually drew the greatest number of fee complaints. What was wrong?

The answer came to him one day when he overheard a conversation in the surgeon's office. A woman patient was going to have an appendectomy, and the surgeon was telling her: "You don't have a thing to worry about. There's nothing to it."

The lady went through with the operation and—sure enough—complained about the surgeon's bill for \$75. "If there's nothing to it," she told the accountant during a follow-up phone call, "I don't see why he should charge so much."

Part of the trouble here, of course, was the surgeon's failure to discuss fees in advance. But equally troublesome was his habit of deprecating

SIDE LIGHTS

ing his own services. When these things were pointed out to him, he found it simple to avoid further complaints.

Do the words *you* use stir up unwarranted reactions when the patient gets your bill? As in the example cited, you may never know unless you turn to some outside source.

One such source is this month's article, "Don't Sell Yourself Short." Better see how your semantics measure up to those it suggests.

Move to the Country

Not so many years ago, small-town practice was widely regarded as an economic dead end. Doctors crowded into our largest cities even though

many of them would have preferred country life.

"I can't afford to practice where I'd really like to practice," one transplanted Iowan told us a while back, as we chatted in his Chicago walk-up.

Yet just recently, our friend moved back to Iowa. He's already well established in a town of 4,500. He has a lovely home, with adequate hospital facilities just forty minutes away. "I should have made this move long ago," he wrote the other day.

We mention this one-man migration because it's indicative of a trend. At least the economic facts point that way. They show, for example, that:

¶ The small-town doctor's aver-

THE
WORLD'S
FIRST THOROUGHLY
STUDIED
ANTIBIOTIC
FOR
HUMAN
USE

ILOTYCIN

ERYTHROMYCIN, LILLY
CRYSTALLINE

Lilly

ferred
where
the trans-
the back,
walk-

moved
well es-
He has
hospi-
away.
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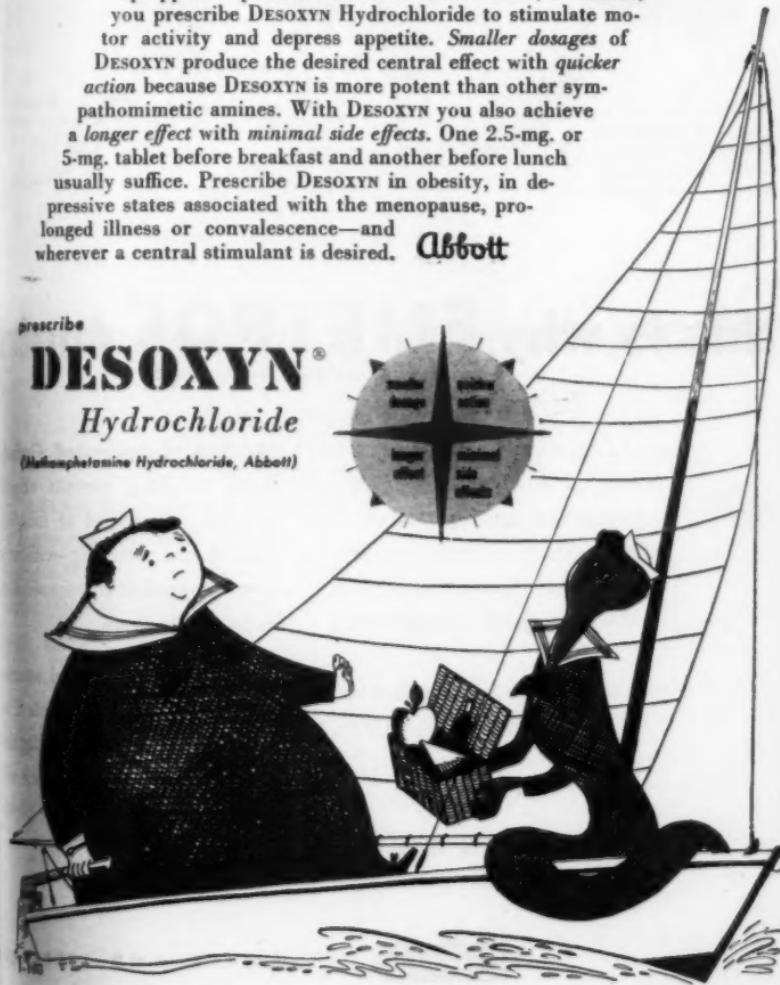
When Temptation is his shipmate

JUST a taste of fresh air and exercise and his keyed-up appetite spells doom for his diet. Unless, of course, you prescribe DESOXYN Hydrochloride to stimulate motor activity and depress appetite. Smaller dosages of DESOXYN produce the desired central effect with quicker action because DESOXYN is more potent than other sympathomimetic amines. With DESOXYN you also achieve a longer effect with minimal side effects. One 2.5-mg. or 5-mg. tablet before breakfast and another before lunch usually suffice. Prescribe DESOXYN in obesity, in depressive states associated with the menopause, prolonged illness or convalescence—and wherever a central stimulant is desired. **Abbott**

prescribe

DESOXYN®
Hydrochloride

(Norepinephrine Hydrochloride, Abbott)



Kymographic recording shows normal contraction of rabbit jejunum in 100 cc. of Tyrode's solution.



Adding 0.5 cc. of EMETROL immediately relaxes the muscle... reduces rate and amplitude of contraction.

this is why **EMETROL** controls

(PHOSPHORATED CARBOXYDRATE SOLUTION)

EMETROL Phosphorated Carbohydrate Solution permits effective physiologic control of functional nausea and vomiting—without recourse to antihistaminics, sedatives or hypnotic drugs.

Pleasantly mint flavored, EMETROL provides balanced amounts of levulose and dextrose in coating association with orthophosphoric acid, stabilized at an optimal, physio-

SAMPLE AND LITERATURE ON PHYSI

Kinney

When the EMETROL solution is replaced with fresh Tyrode's solution, normal contraction resumes.



Contraction virtually ceases with addition of 1.5 cc. of EMETROL.



Controvertible vomiting physiologically

Carboxylogically adjusted pH level.

effective
functional
without re-
sedatives

EMETROL
ants of lev-
ting associ-
onic acid,
physio-

Thus, EMETROL can be given safely—by teaspoonfuls for children, tablespoonfuls for adults—at repeated intervals until vomiting ceases.

IMPORTANT: EMETROL is always given undiluted. No fluids of any kind should be taken for at least 15 minutes after taking EMETROL.

INDICATIONS: Nausea and vomiting resulting from functional disturbances, acute infectious gastroenteritis or intestinal "flu," pregnancy, motion sickness, and administration of drugs or anesthesia.

SUPPLIED: Bottles of 3 fl.oz. and 16 fl.oz., at all pharmacies.

KINNEY & COMPANY
COLUMBUS, INDIANA

RATED PHYSICIANS ON REQUEST

SIDE LIGHTS



IT'S BACK... and better than before!

Yes, the Fairbanks-Morse Health Scale is back again, and with the same true accuracy and dependability to serve you over the years. This new model, No. 1265, is noted for its easy-to-use features and its smart, neat appearance. And the special attention given to the design and durability of the wearing parts assures its long life and trouble-free performance. Fairbanks, Morse & Co., Chicago 5, Ill.



FAIRBANKS-MORSE

a name worth remembering

SCALES • PUMPS • ELECTRIC MOTORS
GENERATORS • LIGHT PLANTS • DIESEL, DUAL
FUEL AND GASOLINE ENGINES • MAGNETOS

age net earnings have risen almost 200 per cent in the last twenty years, the big-city physician's average net earnings have risen only about 50 per cent.

The small-town doctor now net \$13,870, on the average. Not only does the big-city doctor earn slightly less (\$13,104); his earnings beat him considerably less, in the face of metropolitan prices.

Yet the myth dies slowly. You can still find plenty of metropolitan physicians who'd do better in the country but who don't realize it. And this, of course, simply prolongs our profession's maldistribution.

What's the answer? Wider dissemination of the facts will help. Hence our survey report on the subject, appearing in this issue.

Lesson From Chiro

It may seem incredible that the medical profession can learn anything useful from chiropractors. But the disciples of Daniel D. Palmer have given us a neat object lesson in the value of backing up one's professional organizations with cash.

Physicians tend to think they're doing all right in this respect. Yet in Indiana, for example, at a time when state medical society dues were \$35 annually, the chiropractors were collecting \$240 per member per year.

This disproportion exists in other states. It helps explain the chiropractors' disproportionate success in winning public favor (see page 128).

for RAPID
SUSTAINED
CONTROLLABLE
REDUCTION OF
Critically Elevated
Blood Pressure

SOLUTION

INTRAMUSCULAR VERILOID

Injected deep into the muscle, a single dose attains its maximum hypotensive response in 60 to 90 minutes. By repeated injection every 3 to 6 hours, the blood pressure may be kept depressed for hours or days if necessary. Solution Intramuscular Veriloid provides 1.0 mg. of alkavervir (mixed Veratrum viride alkaloids) per cc. of isotonic buffered aqueous solution.

SOLUTION

INTRAVENOUS VERILOID

Given in proper dilution slowly by vein, Solution Intravenous Veriloid usually reduces both the systolic and diastolic blood pressures in a matter of minutes—entirely within the control of the physician. This valuable emergency drug frequently proves to be a life-saving measure. Contains 0.4 mg. of alkavervir (mixed Veratrum viride alkaloids) in 0.25 per cent acetic acid solution.

THE PARENTERAL SOLUTIONS OF

Veriloid



Acting rapidly in a significantly high percentage of patients, the parenteral solutions of Veriloid afford a positive means of reducing critically elevated blood pressure. They have been found of great value for the relief of the distressing symptoms of prolonged, severe blood pressure elevation, and in hypertensive emergencies when the degree of hypertension assumes life-threatening proportions. These parenteral hypotensive agents are indicated in hypertensive states accompanying cerebral vascular disease, malignant hypertension, hypertensive crisis (encephalopathy), toxemias of pregnancy, pre-eclampsia, and eclampsia.

RIKER LABORATORIES, INC.
8480 BEVERLY BLVD., LOS ANGELES 48, CALIF.

VERILOID, GENERICALLY DESIGNATED ALKAVERVIR, IS

An Original Riker Research Product

case briefs from published reports

The blood pressure remained considerably reduced... there has been much subjective improvement, and the patient has returned to full work."¹



FROM 250/160 mm. Hg. to 150/95

BY MEANS OF

Veriloid



Veriloid is available in three dosage forms:

Veriloid (plain) in 1, 2, and 3 mg. scored tablets; starting dosage 9 to 15 mg. daily, to be adjusted according to response and tolerance.

Veriloid with Phenobarbital (Veriloid-VP), each scored tablet presenting Veriloid 2 mg. and phenobarbital 15 mg.

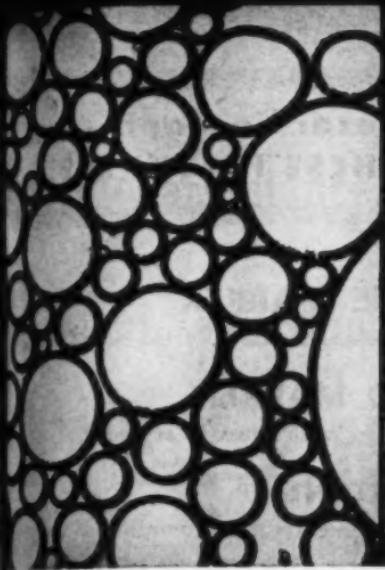
Veriloid-VPM, each scored tablet containing Veriloid 2 mg., phenobarbital 15 mg., and mannitol hexanitrate 10 mg. Initial recommended dosage for VP and VPM, 1 to 1½ tablets t.i.d. or q.i.d.

This male patient, 41 years of age, was given the same dose of Veriloid tablets (26 mg. daily) for a period of five months. During that time, he was able to resume his normal sedentary occupation at full activity. Note the prompt and sustained reduction in diastolic pressure and the subsequent good reduction in systolic pressure.

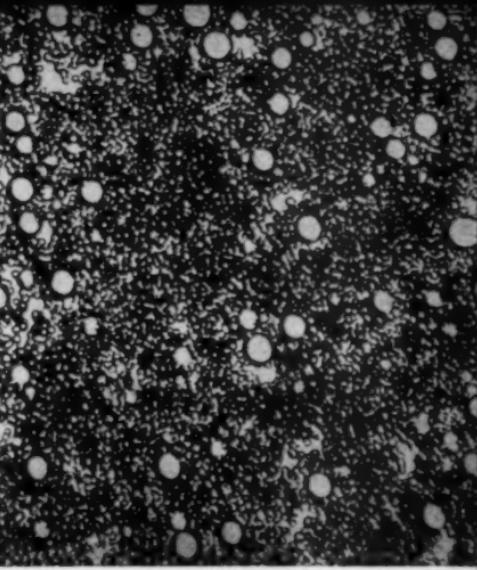
Not every patient shows this spectacular response to oral Veriloid. However, a sufficiently large number do, warranting the administration of this hypotensive agent to every patient with elevation of blood pressure sufficient to require treatment.

*Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid, *Lancet* 2:1002 (Dec. 1) 1951.

RIKER LABORATORIES, INC. • 8480 BEVERLY BLVD. • LOS ANGELES 48, CALIF.



Oil dispersion (x133). Large irregular globules fail to mix readily with fecal mass. Phenolphthalein is not evenly distributed to stimulate bowel action. Action may be sporadic and evacuation incomplete.



2 The fine oil emulsion (x133) of Agoral. The small, uniform globules and the phenolphthalein mix readily with the bowel content, producing peristalsis by more uniform lubrication and stimulation.

Which Laxative is Better — COARSE DISPERSION OR FINE EMULSION?

Coarse dispersions are unstable, and erratic in their effects. Any physician can recognize the superiority of the fine Agoral emulsion (*at right, above*) compared with an ordinary oil-in-water dispersion (*left*).

Free-floating oil is distasteful and often regurgitated. Large oil globules tend to coalesce and form pools in the gut, which may seep past the sphincter as anal leakage.

Agreeable to Sensitive Stomach

The fine emulsion of Agoral is palatable and will not distress a sensitive stomach. It assures more uniform dosage and distribution of the active ingredients, more uniform clinical results. Its thorough admixture with the

bowel content gives effective, uniform lubrication of the fecal mass as well as the canal. There is no loose oil to cause anal leakage.

Mixed like Homogenized Milk

Agoral is emulsified exclusively with refined white mineral oil, purified white phenolphthalein, agar-gel, tragacanth, acacia, egg-albumen and glycerin, by a special process similar to that used for homogenizing milk.

For over 30 years medical men have obtained results with Agoral with a uniformity and precision which are a constant source of satisfaction both to them and to their patients.

WARNER - CHILCOTT LABORATORIES
Division of Warner-Hudnut, Inc.,
New York 11, N. Y.

Prescribe **AGORAL** **WARNER**
DIETARY AND GENTLY EFFECTIVE WITHOUT DISTRESS OR LEAKAGE

Your New Electrocardiograph--
WILL IT HAVE THESE FEATURES?

CONTINUOUS TIME MARKER

independent of the chart; assures accuracy of the time factor.

AUTOMATIC LEAD MARKER

obviates guesswork; you *know* which lead is recorded.

PRECISION RECORDING

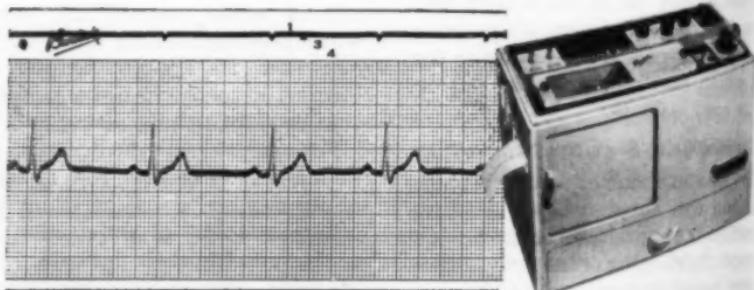
sensitive to rapid changes in potential; no rounding of sharp peaks.

SIMPLE OPERATION

selection of lead at the turn of a switch; rapid calibration; controls all on one panel; portability; a clear, permanent record.

All these features are available in the

Burdick
E K - 2
DIRECT-RECORDING
ELECTROCARDIOGRAPH



THE BURDICK CORPORATION MILTON, WISCONSIN

Nutritional balance
in
weight reduction



DIETENE® REDUCING SUPPLEMENT



Reducing can be accomplished without cellular starvation. With Dietene a well-rounded nutritive intake assures an adequate reserve of basic dietary factors.

Appetite-satisfying

Delicious-tasting Dietene Milk Shake (skimmed milk and Dietene) provides maximal amounts of protein, vitamins and minerals with a minimum of calories. Taken in mid-morning and mid-afternoon, it satisfies the appetite for food and makes it easier for the patient to adhere to his diet.

Physicians' Diet Service

The Dietene Company will be glad to send you a supply of 1000-calorie diet sheets, with or without restricted sodium intake. These diet menus, designed to be used with Dietene, in-

clude an easily-prepared, palatable selection of foods.

No calorie-counting is required; no special preparations needed—the sheets are prepared without advertising, to look as though typed especially for the patient.

SEND THIS
COUPON

for complimentary
diet service

THE DIETENE COMPANY
3017 Fourth Avenue So., Minneapolis 8, Minn.

DE 43

Please send me a generous sample of Dietene Reducing Supplement, and a supply of advertising-free diet sheets.

1000-calorie Restricted-Sodium 1000-calorie

M. D.

ADDRESS _____

CITY _____

ZONE _____ STATE _____

ANOTHER STEP FORWARD IN A NEW FIELD OF THERAPY

Recognition of premenstrual tension as a condition requiring specific treatment was pioneered by the introduction of M-Minus 4. In addition to directing attention to this prevalent condition, the product has also given substantial relief in a large percentage of the cases treated.

Another step forward is the announcement of M-Minus 5—an improvement in the formula, and offering definite advantages in both effectiveness and tolerance.

M-Minus 5 now contains *pamabrom*, a new chemical entity which inhibits the ADH (anti-diuretic hormone) of the posterior pituitary. This hormone is held responsible for the unpleasant symptoms of water toxemia—breast engorgement and tenderness, abdominopelvic swelling, cramps and backache, as well as the psychic changes which occur during the premenstrual and early menstrual period.¹⁻⁵

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1. *Neurology*
2. *Obstetrics & Gynecology*
3. *Obstetrics & Gynecology*
4. *Layman's Medical Journal*

IN PREMENSTRUAL AND
MENSTRUAL DISTRESS

M MINUS 5

TRADE MARK

ADDED THERAPEUTIC EFFICIENCY

Controlled laboratory tests show this compound to have a 20 percent greater therapeutic efficiency than M-Minus 4.

ABSENCE OF DROWSINESS

With M-Minus 5 no drowsiness or dizziness is reported. Control tests fail to reveal any toxic effects.

The therapeutic potential of M-Minus 5 is further enhanced with a reliable analgesic for the control of pain and lessening of irritability, anxiety, insomnia. M-Minus 5 does not upset the normal hormonal balance of the menstrual cycle; will not cause the patient to feel "drugged" or sleepy.

FORMULA: each capsule contains—

2-amino-2-methyl-1-propanol-8-bromotheophyllinate (pamabrom).....	50 mg.
Acetophenetidin.....	100 mg.

Bottles of 24 and 100 tablets

Whittier
LABORATORIES

Chicago 11, Illinois

DIVISION NUTRITION RESEARCH LABORATORIES, INC.

REFERENCES:

1. Hume, E. G.: Lancet 2:791 (1946).
2. Holmes, W.: New England J. M. 243:645 (1950).
3. Hollman, F. H. and Farr, L. E.: Ann. Int. M. 14:42 (1940).
4. Lloyd, C. W. and Lobotsky, J.: Am. J. M. 7:419 (1949).
5. Holmes, W. L. (in press).

Prescribe suspensors by Johnson & Johnson

A TYPE FOR EVERY PATIENT

Rx
*—the same name
you trust for
surgical dressings*

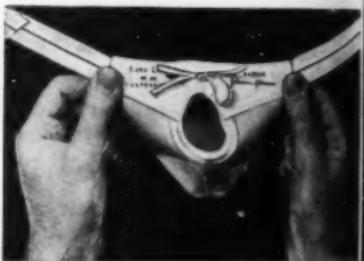
BOTH you and your patients have confidence in the familiar Johnson & Johnson name. For 66 years, it has stood for the finest in surgical products.

Johnson & Johnson Suspensors are designed for practical comfort and protection and are fashioned from the best materials. Where elastic is used, for instance, it's that long-lasting PERMOFLEX webbing — identified by the black stripe.

Remember Johnson & Johnson when the wearing of a suspensor is indicated. It also helps to fight fatigue. Sold at surgical supply dealers and drug stores.



J. P. 45 Without legstraps. Many slender men prefer its freedom. Elastic strip in yoke is self-adjusting. Large, Medium, Small.....\$1.50



No. 101 Without legstraps. Drawstring in yoke can be adjusted. Knitted pouch is suspended from sides, for upward lift. L.M.S.....\$1.50



Lister's No. 10 Legstraps offer greater immobilization. Felt pad under waistband buckle and chamois pad in crotch. L.M.S.....\$1.50
Also available, Lister's No. 4 leg type, \$1.00;
and the de luxe Diamond J, \$1.50.



Make the business side of your practice easier ...more profitable (*try out this new and different*) *dictating machine*)

You read *Medical Economics* to find out about just such business helps as Dictaphone TIME-MASTER, the dictating machine that can save you time and trouble, give you a better net income.

No cure-all, of course, yet this simplest and best dictating machine can cut the time of writing up clinical notes in half . . . relays messages to

colleagues, nurses, and assistants accurately . . . frees you to see more patients per day . . . allows you to organize and collect your thoughts for publication.

AND—just to get into the psychosomatic part of it—it may well relieve nervous tension, just by virtue of bringing more certainty into your approach to new problems.

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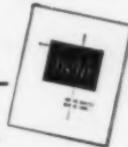
Please send me, without any obligation, your booklet for doctors.

Name _____

Street _____

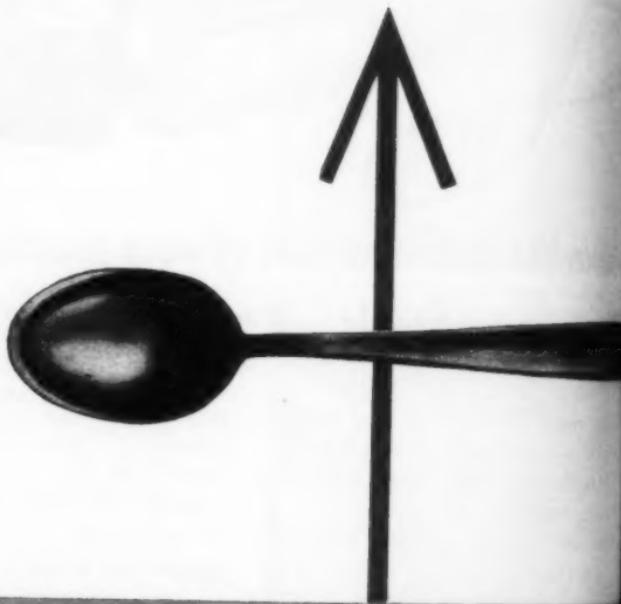
City & Zone _____ State _____

I would like to have a Dictaphone man
call on me . . .



for higher penicillin

blood levels



rely on the **ESKACILLINS***
the palatable liquid penicillin preparations for oral use

Because they are readily soluble in gastric juice, the 'Eskacillins' are more rapidly absorbed than are the newer, highly insoluble salts of penicillin such as benzethacil. Consequently, you obtain far higher blood levels with the 'Eskacillins'.

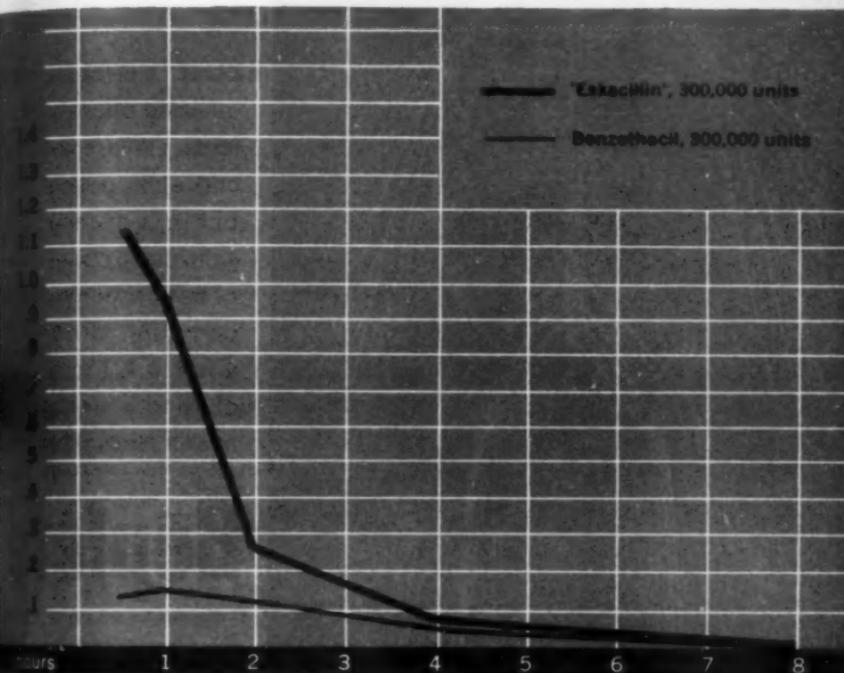
Smith, Kline & French Laboratories, Philadelphia

* U.S. Pat. Off.

comparison of the average serum concentrations in the same patients after a single oral dose . . .

(averages of a series of patients, oral fasting)

'Eskacillin' vs. one of the newer, highly insoluble penicillin salts



Source: Foltz, E.L., and Schimmel, N.H.: Antibiotics & Chemotherapy, to be published.

per teaspoonful



the 'Eskacillins'

'Eskacillin 50'

50,000 units potassium penicillin G

'Eskacillin 100'

100,000 units potassium penicillin G

'Eskacillin 250'

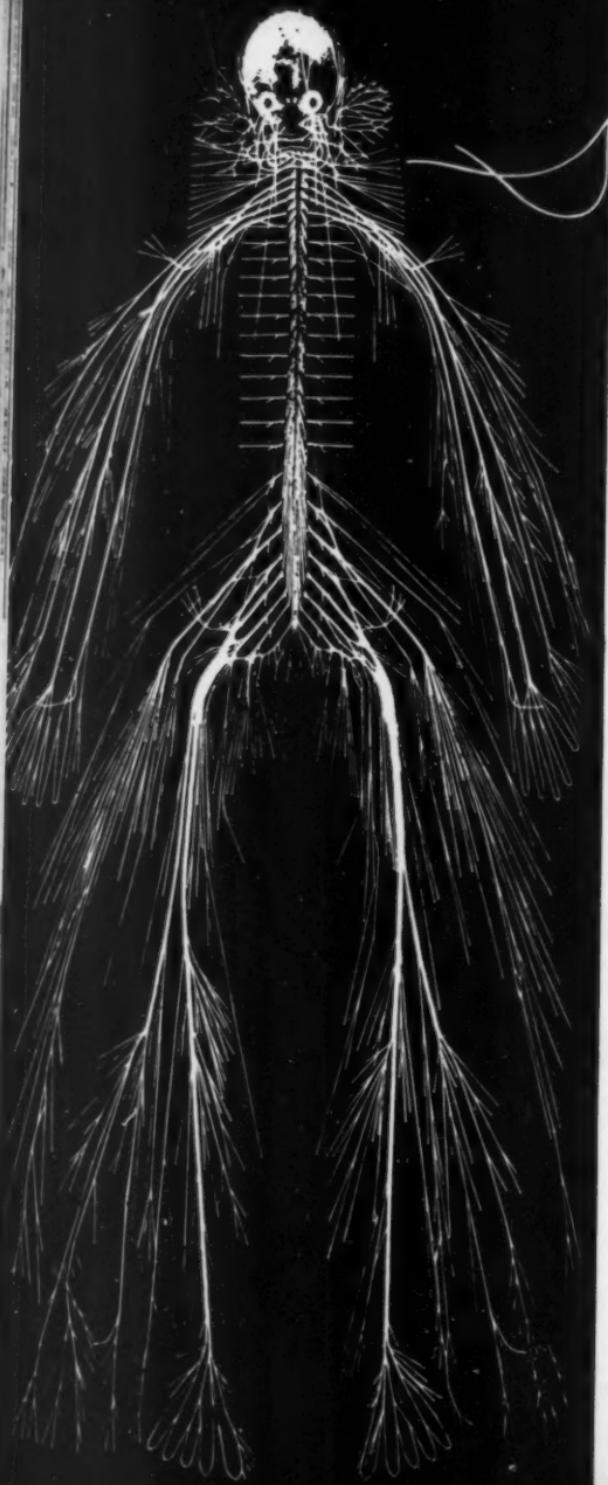
250,000 units procaine penicillin G

'Eskacillin 500'

500,000 units procaine penicillin G

Combined penicillin-sulfonamide therapy:

'Eskacillin 100-Sulfas' and 'Eskacillin 250-Sulfas'



To UNTANGLE
that
bundle
of nerves

BÉPLETE—for its tranquilizing effect on your tense, overemotional, anorectic patient. The BÉPLETE formula is a judicious combination of low dosage sedation and high dosage of vitamin B factors, including therapeutic quantities of vitamin B_D.

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← Dissection of nervous system by R.B. Weaver, A.M., M.D., Sc.D., late Professor of Anatomy, Hahnemann Medical College and Hospital. Courtesy of Hahnemann Medical College Museum.

Letters

Splits by surgeons • Morality in

medicine • Smoking on the job • Income survey hit • Making fees public? • No hurrahs for A.F.M.C. • D.S.C. praises M.D.'s • Mutual funds • Magnuson's 'cure-all'

Splits by Surgeons

Sirs: Since MEDICAL ECONOMICS became the sounding board for those physicians who desire to make fee splitting an honorable practice, the American College of Surgeons has frequently been attacked in your columns as "a minority group seeking to impose its will upon the entire medical profession."

At last December's Clinical Session of the A.M.A., the House of Delegates approved the following Judicial Council interpretation of Section 5 of Article VI of the Principles of Medical Ethics:

"This means that the physician who takes a patient over for treatment from another physician should render a bill direct to the patient for such treatment. If this happens to be a surgical case and the doctor referring the patient assists in the operation, gives the anesthetic or participates in any way in the treatment of the patient, the doctor so participating should render his own bill direct to the patient, and it should not be part of the surgeon's bill." (The italics are mine.)

This dispels all doubt as to which ethics the A.C.S. is endeavoring to enforce. I would further point out that the Judicial Council's decision disposes of the specious theory that pre- and postoperative treatment by a referring physician is an inseparable part of the entire service rendered a patient.

Paul R. Hawley, M.D.
Director, American College of Surgeons
Chicago, Ill.

MEDICAL ECONOMICS is, indeed, a sounding board as Dr. Hawley says—but not for any one party to a controversy. On the fee-splitting issue, as an example, space has been given, and will continue to be given, to all points of view.—ED.

Morality in Medicine

Sirs: I've just read your editorial entitled, "Outmoded Ethics." When you say that medical ethics are outmoded, you imply that the character of those who practice medicine has changed. You imply, too, that morals and the interpretation of right have also changed. [MORE→]

LETTERS

I'm in profound disagreement with these implications.

You fail to differentiate between the goal and the doctor's attempt to reach it. One almost never attains an objective in morals; but the reputable physician strives continuously to do so. The guideposts of medical ethics have no more changed than have the Ten Commandments.

What you're actually saying in your editorial is that because certain things are being done increasingly in medical practice today, they must necessarily be acceptable. In other words, usage makes right.

Of course, it just isn't so. And to the extent that your editorial spreads this fallacy, it contributes to the widespread social destruction current in the country today.

Frederic P. Shidler, M.D.
Menlo Park, Calif.

We agree completely with Dr. Shidler's contention that basic morals don't change. But the Principles of Medical Ethics, as presently written, don't deal exclusively with basic morals. Revision of the code, we maintain, would strengthen—not weaken—the ethics of modern medicine. How? By clarifying the vague, contradictory, or outmoded provisions now present in the code.—ED.

Smoking on the Job

SIRS: I thought the article, "Eleven Weeks at a G.P.'s Elbow," was fine—except for one thing: In several pictures the genial general practi-

titioner appears in the patient's presence with a cigar.

Unfortunately, I've seen many colleagues, otherwise clean and competent, enter the sickroom carrying a stinking, half-chewed, half-smoked cigar. It's high time we doctors learned not to smell of tobacco, much less smoke, when at the patient's bedside.

George L. Carlisle, M.D.
Dallas, Tex.

SIRS: It's beyond my understanding how you could print such a picture. It's a poor example Dr. Coleman gives his students . . . He owes an apology to the medical profession.

R. Wartenberg, M.D.
San Francisco, Calif.

In this instance as in others, MEDICAL ECONOMICS reported pictorially what it found—instead of what it might have created by artificial posing or by retouching. It did so in the belief that realism, not idealism, is what most readers want.—ED.

Income Survey Hit

SIRS: Recently MEDICAL ECONOMICS reported that the average M.D.'s annual gross income is \$24,770; his net income, \$15,262. These figures quickly made headlines in the lay press.

The unfortunate part of this is the public's unawareness of the fact that for every doctor with a high income there's one with a modest income. The latter have to take crit-

For the nervous patient

with poor appetite

Eskaphen B* elixir & tablets (phenobarbital plus thiamine)

Smith, Kline & French Laboratories, Philadelphia

Available, also:
elixir 'Eskaphen B with Belladonna'
for smooth-muscle spasm

*T.M. Reg. U.S. Pat. Off.

LETTERS

icism that should properly be directed only at the few who report enormous earnings.

It's questionable what your quadrennial survey accomplishes—except to further embitter an already poorly informed public. We physicians should think twice before taking part in polls that merely solidify the opinion that physicians are overcharging and living in luxury at the expense of the unfortunate sick.

M.D., Massachusetts

M.D.'s on Hospital Boards

SIRS: I think it's a mistake to appoint members of the medical staff to the average hospital board. As soon as a staff member is elevated

to a position of authority, his colleagues are likely to set up a cry of favoritism. A physician on the board of directors may, of course, give valuable advice to the board. But such good as he does can be negated by the antagonism of his fellow staff members.

C. L. Mulfinger, M.D.
Los Angeles, Calif.

No Hurrays for A.F.M.C.

SIRS: May I be allowed a few comments on your article about the American Federation of Medical Centers?

The founder of this organization, Dr. Edgar H. Norris, has selected the Health Insurance Plan of Great-

Now for the first time

Tolyphy

Chimedic
safe effective relaxation

of skeletal muscle spasm without loss of normal muscle tone or function.

Exerts the full spasmolytic action of Tolyspa (Chimedic brand of mephenesin) plus the beneficial effects of physostigmine and atropine on the neuromuscular system.

TOLYPHY is specifically designed for the relief of pain, for increased range of motion and restoration of normal function in a wide variety of conditions complicated by skeletal muscle spasm or neuromuscular hyperirritability:

Arthritis, fibrositis, torticollis, bursitis, myositis, low back pain. In paralysis agitans the primary pathology in the central nervous system is often irreversible, but TOLYPHY helps bring relief from the stiffness, tremor, rigidity and painful muscle spasm.

Literature and samples of TOLYSPAZ and TOLYPHY available.

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In both private and hospital practice, oral REMANDEN may be relied upon to save countless hours by supplementing intramuscular therapy in the more commonly occurring systemic infections.

Six advantages of Remanden

1. REMANDEN gives higher and more prolonged penicillemia* than an equal dose of other currently available oral penicillin preparations.
2. REMANDEN provides comparable plasma levels peak-wise and duration-wise—to procaine penicillin intramuscularly.
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4. REMANDEN permits wider latitude in spacing of oral doses, facilitating administration dissociated from meals to obtain optimal absorption.
5. REMANDEN is adequate for the majority of infections due to penicillin-susceptible organisms.
6. REMANDEN allows freedom from injection without sacrificing therapeutic efficacy.

**Synonym for plasma concentrations of penicillin.*

New "Oral Repository Penicillin" ... Comparable to Intramuscular Therapy¹

REMANDEN combines potassium penicillin G with probenecid. Probenecid has been shown to increase penicillin plasma levels from 2 to 10 times. REMANDEN given in the same dosage will increase the stability of current oral penicillin dosage schedules. In a recent clinical report¹ the recommended daily dose of REMANDEN has been shown to give the same peak levels and the same duration of therapy as that provided by the usual dose of procaine penicillin (300,000 units) given intramuscularly.

SOME TIME FOR THE PHYSICIAN

Because REMANDEN maintains plasma levels of penicillin comparable to those of intramuscular penicillin, this new preparation is an important time-saver for

the physician. Perhaps its greatest value is its usefulness in supplementing and augmenting parenteral penicillin therapy —thereby saving the physician many house calls.

DOSAGE:

Each REMANDEN Tablet contains 100,000 units of penicillin and 0.25 Gm. of BENEMID. Adults, 4 REMANDEN Tablets initially, then 2 tablets every 6 or 8 hours. Children, on the basis of 0.025 Gm. of BENEMID per kilogram, 2 to 4 tablets per day. REMANDEN is supplied in vials of 12 (slotted) tablets.

Sharp & Dohme, Philadelphia 1, Pa.

1. Boger, W.P., Crosley, A.P., Jr., Carfagno, S. and Bayne, G.M.: Antibiotics and Chemotherapy, 2:553, November, 1952.

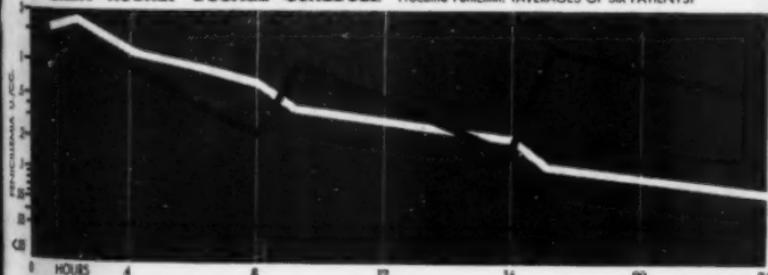
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PENICILLIN WITH PROBENECID (*Benemid*®)

EIGHT HOURLY DOSAGE SCHEDULE

Oral Potassium Penicillin G Plus 'Benemid' VS. Intramuscular Procaine Penicillin. (AVERAGES OF SIX PATIENTS)



Oral administration of REMANDEN at eight-hour intervals maintains over-all plasma penicillin levels during a 24-hour period (black line) equal to those obtained with 300,000 units of intramuscular procaine penicillin (white line).

LETTERS

er New York as his model for the administration of medical care. And he calls H.I.P. "the most practical, forward-looking plan now in operation."

If Dr. Norris had studied H.I.P. more closely, he would have learned that even the doctors now employed by the plan don't think too highly of it. Practically all of them work for H.I.P. only part-time. They still depend for most of their income on that same old-fashioned, inefficient, wasteful, fee-for-service system of private practice that Dr. Norris deplores.

The vague financial arrangements announced by the A.F.M.C. follow a familiar pattern. Doctors

are offered only the old indefinite promises: more security, more time for study and research, hospital connections, etc. (There is no mention of hours of work, pay rates per hour, overtime pay, or "fringe benefits.")

Just such benefits were offered to British physicians, to induce them to sign up with the National Health Service. How those promises were fulfilled is common knowledge.

Lyon Steine, M.D.
Valley Stream, N.Y.

SIRS: It's true that the medical centers advocated by the A.F.M.C. would "discourage 'unproductive' competition among doctors" but it's equally true that they would dis-

CHOLOGESTIN SALICYLATED BILE SALTS

Synergistic salicylization of natural sodium glycocholate and sodium taurocholate accounts for the greater efficiency of Chologestin as a choleric and cholagogue. Thousands of physicians are pre-

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TABLOGESTIN

3 tablets with water are equivalent to 1 tablespoonful Chologestin.

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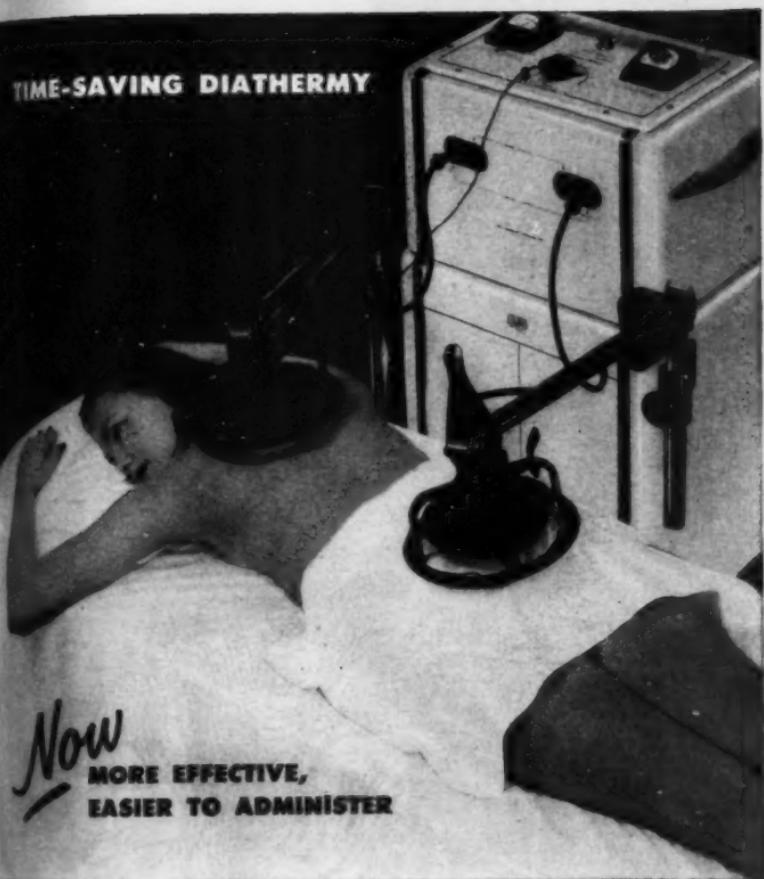
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SCALING

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**ITCHING
SYMPTOMS**



Seborrheic Dermatitis of the scalp... conveniently

applied while washing hair, then rinsed out

An outstanding new treatment for scalp conditions ranging from mild dandruff to severe seborrheic dermatitis, *Selsun* Sulfide Suspension restores the scalp to a normal, healthy condition (usually within 6 weeks) ... after which scaling is kept under control with applications at 1 to 4 week intervals. Itching and burning symptoms are relieved after only two or three applications.

In clinical trials with 400 patients^{1,2,3} investigators reported *complete control* in 92 to 95 percent of cases of common dandruff, and in 81 to 87 percent of all cases of seborrheic dermatitis. In these studies, *Selsun* often proved effective in cases where other medications had been unsuccessful.

Applied and rinsed out during the patient's hair washing routine, *Selsun* is convenient to use, leaves the scalp clean and odorless. Toxicity studies^{1,2} show there are no ill effects from external use as recommended. Supplied by pharmacies in 4-fluidounce bottles, *Selsun* is dispensed only on the prescription of a physician. **Abbott**

WRITE FOR LITERATURE on this outstanding new product.

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References:

1. Slinger, W. N., and Hubbard, D. M. (1951), Arch. Dermat. & Syph., 64:41, July.
2. Slepyan, A. H. (1952), Ibid., 65:228, February.
3. Ruch, D. M. (1951), Communication to Abbott Laboratories.

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If Your Patients Can't Tolerate
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Nicotine Actually Bred Out Of The Leaf

John Alden cigarettes are made from a completely new, low-nicotine variety of tobacco. A comprehensive series of smoke tests*, completed in 1951 by Stillwell and Gladding, one of the country's leading independent laboratories, disclose the smoke of John Alden cigarettes contains:

- At Least 75% Less Nicotine Than 2 Leading Denicotinized Brands Tested
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Importance To Doctors And Patients

John Alden cigarettes offer a far more satisfactory solution to the problem of minimizing a cigarette smoker's nicotine intake than has ever been available before, short of a complete cessation of smoking. They provide the doctor with a means for reducing to a marked degree the amount of nicotine absorbed by the patient without imposing on the patient the strain of breaking a pleasurable habit.

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IN JOHN ALDEN CIGARETTES**

John Alden cigarettes are made from a *completely new variety of tobacco*. This variety was developed after 15 years of research by the Kentucky Agricultural Experiment Station. Because of its extremely low nicotine content, it has been given a separate classification, 31-V, by the U. S. Dept. of Agriculture.



*A summary of test results
available on request.

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cigars and pipe tobacco.

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LETTERS

courage "productive" competition.

Doctors don't want more security through salaried practice and retirement plans. If that's what they wanted, they wouldn't study medicine in the first place. They'd do something that requires less than ten years of the hardest study and an outlay of \$35,000 for expenses.

Leon Ropschutz, M.D.

New York, N.Y.

D.S.C. Praises M.D.'s

SIRS: I wish to express my appreciation for Don Cameron's fine article, "The Facts About Chiropody."

It has been my privilege to serve as Examiner in Chiropody on the Ohio State Medical Board for the past ten years, and I can vouch for the pleasant relationship that exists between members of my profession and the medical profession. Chiropodists and M.D.'s should be valuable allies; and in my experience, they often are.

H. L. Collins, D.B.C.

Past President

American College of Chiropody
Columbus, Ohio

Mutual Funds

SIRS: Everett J. Mann's article, "Don't Go Overboard on Mutual Funds," is one of the best ever published.

Most of the statistics you see on mutual funds cover periods when, for the most part, stock prices were going up. But how the funds have performed in declining stock markets is equally important. [MORE→]

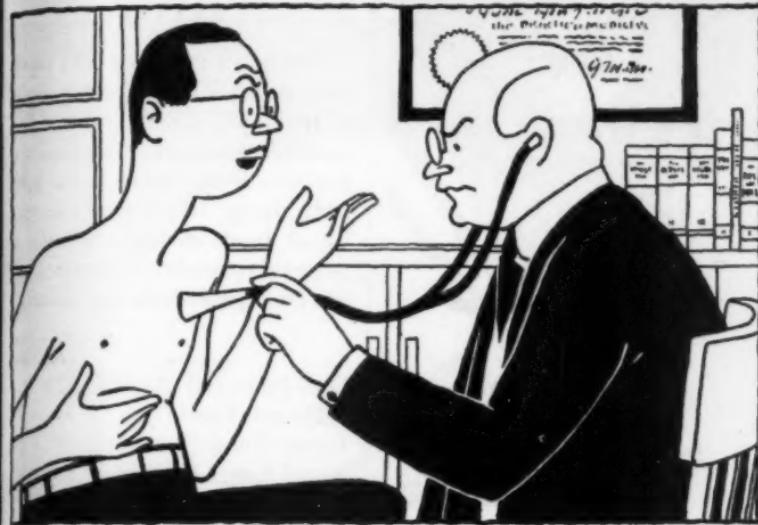
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MEDICAL MOMENTS ... SELF DIAGNOSIS

"Doctor, wouldn't you say the pathology of my type of low-grade rickettsial infection indicates the use of aureomycin? I've just read . . ."

You probably have your share of local irritants that you've just got to tolerate. Like seekers of free advice, midnight callers . . . and amateur medicos like the one pictured above.

But there are certain other irritations you don't have to put up with. One of them is hospital hands; hands that get tender and sore from frequent and energetic scrubbings. Not when it's so easy and so pleasant to keep them smooth and comfortable with Noxzema. It's delightfully soothing — helps heal the tiny cracks. And Noxzema is greaseless, too. No greasy mess on your hands.

Here's another good tip. Rub a little Noxzema on your feet some

night when they're hot and tired after a hard day. See how cool and refreshing it feels, how much better you feel afterwards!

For Your Information

Regular Noxzema Skin Cream is a modernization of Carron Oil, fortified by adding Camphor, Menthol, Oil of Cloves and less than 1/2% of Phenol in a greaseless, solidified emulsion. Its reaction is almost neutral—the pH value being 7.4.

If you haven't tried Noxzema Skin Cream, we will be happy to send you a generous complimentary jar. Just drop a card to Noxzema Chemical Company, Baltimore 11, Md.

LETTERS

Nearly all investors who owned mutual funds in the falling market of 1937-1942 saw the value of their investments shrink. The same was true to a lesser extent in the 1946-1949 slump. Here's how a selected list of funds *declined* in value in those two periods, as compared with the Dow-Jones Industrial Average:

	1937 - 1942	1946-1949
Dow-Jones Ind. Av.	52%	25%
Affiliated Fund	75	43
Boston Fund (balanced)	60	23
Broad Street Investing	58	34
Commonwealth Fund (balanced)	52	24
Dividend Shares	55	29
Eaton & Howard (balanced)	42	17
Eaton, Howard (stock)	54	17
Fidelity Fund	57	29
Fundamental Investors	51	32
Incorporated Investors	71	38
Mass. Investors Trust	58	31
National Investors	49	39
Wellington (balanced)	40	19

a new organic complex of iron for iron deficiency anemias

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iron choline citrate

NO GASTROINTESTINAL DISTRESS

...does not precipitate protein and is not astringent

BETTER ABSORPTION

...soluble throughout the entire pH range of the gastrointestinal tract



Three tablets or one fluid ounce of Ferrolip supplies 1.0 Gm. of Iron Choline Citrate equivalent to 120 mg. of elemental iron and 360 mg. of choline base.

FERROLIP Tablets:

1 or 2 three times daily.

Supplied: Bottles of 100, 500 and 1000.

FERROLIP Liquid:

2 to 4 teaspoonfuls three times daily.

Supplied: Pints and gallons.

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When prices have declined, the *balanced* funds have generally acted better than the *common-stock* funds. This is to be expected, of course, since most balanced funds are at least 30 per cent in bonds and high-grade preferred stocks. But the balanced funds haven't acted sufficiently better than some stock funds in bear markets to make up for their sluggishness in bull markets.

There are well over a hundred open-end mutual funds, but only a dozen or so look good from an in-

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Average:

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42 100
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flat iron sharp cutting edge even after many
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standard springs. Vix Gamma
sterilized steel needles also available
in standard sizes.

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available at your surgical supply dealers

LETTERS



Deepfreeze Dilemma

Patients who find it impossible to retire without a pantry picnic often regret it when acid indigestion causes them a sleepless night. At times like this they will really appreciate the fast, long-lasting relief provided by BiSoDol. This reliable antacid efficiently neutralizes the excess gastric juices responsible for the upset. BiSoDol has a pleasant minty flavor—is extremely well tolerated. Whenever your patients require fast, long-lasting relief from acid indigestion, you can recommend BiSoDol Mints, Powder, or new BiSoDol Chlorophyll Mints with confidence.

BiSoDol® tablets or powder

WHITEHALL PHARMACEUTICAL COMPANY
22 East 40th Street, New York 16, N. Y.



vestment viewpoint when analyzed through both upward and downward cycles. These few have fine ten-to-fifteen-year records as compared with the Dow-Jones Average.

For over-all performance in good times and bad, mutuals like Eaton & Howard Stock Fund, Fidelity Fund, and Fundamental Investors have impressive records. They haven't been so profitable to the investor as Standard Oil of New Jersey, Santa Fe, Sears Roebuck, and some other individual stocks, but they've done better than the average of the standard quality stocks.

But because of the "loading charge" the buyer pays—and for other reasons—mutual fund shares are inherently long-term holdings. Anyone who buys them on any other basis will be disappointed.

Ralph Sommers
Chicago, Ill.

Magnuson's 'Cure-All'

SIRS: In a recent article on the Magnuson Report, you quote Dr. Magnuson as follows: "Too many people are looking for little green pills that will cure all their troubles—and there ain't none. Too many other people don't want any interference with the cultivation of their own private gardens. Medical care problems are too pressing for us to tolerate either point of view."

One wonders who the intolerant "we" really are.

Apparently, what Magnuson and his commission want is compulsory

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when she's Imprisoned by FATIGUE

... you may free her from iron-deficiency anemia by the simple expedient of prescribing one IBEROL tablet t.i.d.

As you can see by the formula, three IBEROL tablets provide a therapeutic dose of iron plus seven B complex factors including B₁₂. In addition, IBEROL supplies standardized stomach-liver digest and ascorbic acid.

Compressed, triple-coated IBEROL tablets are easy to take with no trace of liver odor or taste.

The outer sugar-coating masks the iron, gives the tablet a pleasant odor and flavor.

For prophylaxis in pregnancy, old age or convalescence, one or two tablets are usually enough. May be used as a supplemental hematinic in pernicious anemia. IBEROL is available in bottles of 100, 500 and 1000. **Abbott**

THREE IBEROL TABLETS: the average

daily therapeutic dose for adults, supply:

Form: Tablets..... 1.05 Gm.
containing 210 mg. elemental iron, the active
agent for the increase of hemoglobin in the
treatment of iron-deficiency anemia;

For these additional constituents:

Tetrahydrofolic Acid (5 Grams DHA [®])	6 mg.
Thiamine (1 Gram BCA [®])	6 mg.
Riboflavin (2 Grams BCA [®])	30 mg.
Niacin (1 Gram BCA [®])	150 mg.
Pantothenic Acid	3 mg.
Vitamin H	6 mg.
Biotin	30 mcg.
Ascorbic Acid	2.5 mg.
Stomach-Liver Digest	1.5 Gm.

100-Milligram Daily Requirement
100-Recommended Daily Dietary Allowance

prescribe

IBEROL

(Iron, B₁₂, Folic Acid, Stomach-Liver Digest,
With Other Vitamins, Abbott)

LETTERS

sickness insurance. The commission's report doesn't specifically recommend it; but that seems to be the ultimate aim. I doubt that anyone who has watched the development of socialism in the world would fail to recognize the commission's program as a foot in the door.

People here have a right to look for as many little green pills as they wish. They also have a right to cultivate their own private gardens without interference. Let Magnuson quit playing God and get back to the care of the sick.

John K. Glen, M.D.
Houston, Tex.

SIRS: I've read many comments on the Magnuson Report; but none of

them has raised this important question: Would the proposed Government subsidy of prepayment plans mean that there could be only one such plan in each state or area? If so, the advantages of competition would be lost.

Medical care insurance is a rapidly growing field, yet one with which we've had comparatively little experience. Experimentation with new forms and new methods is badly needed. And improved techniques are best developed by the stimulus of competition. Any approach that would freeze existing patterns would be an obstacle to progress.

Arthur H. Harlow Jr.
President, Group Health Insurance
New York, N.Y.

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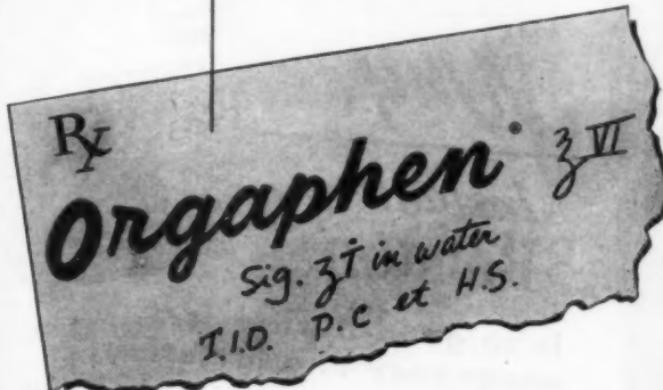
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THEN: Lower the Blood Pressure...
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Relief of the subjective symptoms accompanying high blood pressure may completely rehabilitate a hypertensive patient. Whereas, *mere lowering of blood pressure without relief of symptoms*, serves no such purpose.

The patient receiving ORGAPHEN WAMPOLE experiences relief of the disturbing subjective symptoms. A fall in blood pressure usually follows this subjective improvement.

ORGAPHEN WAMPOLE, the unique elixir of *organically bound iodine* and phenobarbital, has become a useful tool in the management of hypertension.

Each 4 cc. (teaspoonful) contains:

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The low effective dose of the small quantity of phenobarbital in ORGAPHEN is potentiated by the synergistic action of ORGANIDIN. The smaller dose of phenobarbital tends to preclude neuroses frequently resulting from the larger doses more commonly employed.

Supplied in 16-oz. bottles.

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INCORPORATED

Am. J. Med. 4:875, 1948. Slaughter, Donald; Grover, Wm. C., and Hawkins, Richard. Report to American Therapeutic Society, Boston, 1950.

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**Whole Wheat, with 5% Extra Wheat Germ
Twice as Much as in Natural Whole Wheat**

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Contains *all* nutrients of whole wheat plus *all* those of the extra wheat germ.

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To meet the extra needs of pregnancy and lactation.

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Only 21 calories per double-square wafer—no added sugar or fat as in most breads.

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More so than soft, quickly eaten breads, for Ry-Krisp is so crisp, so chewy one eats more slowly and so is satisfied with less.

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All the protein, minerals, B-vitamins of whole-grain rye.

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Absorbs moisture which increases bulk, delays hunger.



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For adults, 1200 and 1800 calories. In booklet form.

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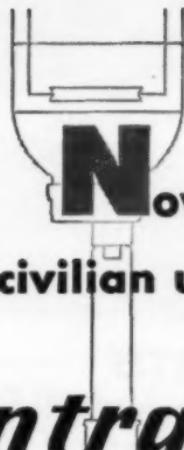
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Also Domnatal Plus Tablets, same formula, plus essential B-vitamins.



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PAIN and of EMOTIONAL REACTION to

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Codeine "Robins", through the multiple synergism of its ingredients, provides maximum safe analgesia...with equally essential control of the entire pain-reaction pattern.

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**Immediate Symptomatic Relief
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—features for the first time the reliable analgesia of salicylamide, the muscle-relaxing qualities of mephenesin, and the time-proved antiarthritic steroid, Ertron.

Especially valuable in the initial stages of arthritis therapy, when rapid relief from pain is indicated.

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Activation products (activated vaporized ergosterol-Whittier Process—biologically standardized) having antirachitic activity of fifty thousand U.S.P. units.....	5 mg.
Salicylamide.....	162 mg.
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Decisive studies substantiate over years of daily clinical use regarding the ability of Desitin Ointment to protect, soothe, dry and accelerate healing in

- diaper rash • exanthem
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(due to urine, excrement, chemicals or friction)

Desitin Ointment is a non-irritant blend of high grade, crude Norwegian cod liver oil (with its unsaturated fatty acids and high potency vitamins A and D in proper ratio for maximum efficacy), zinc oxide, talcum, petrolatum, and lanolin. Does not liquefy at body temperature and is not decomposed or washed away by secretions, excretions, urine or excrements. Dressings easily applied and painlessly removed.

Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars write for samples and literature

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1. Neimer, C. B., Grayzel, H. G. and Kramer, B.: *Archives of Pediatrics*. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bahroll, A. and Lovell, R.: *Ind. Med. & Surg.* 18:512, 1949.

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Prelude to asthma?

not necessarily . . .

Tedral, taken at first sign of attack, often forestalls severe symptoms.

In 15 minutes...Tedral brings symptomatic relief with a definite increase in vital capacity. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

For 4 full hours...Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

Prompt and prolonged relief with Tedral can be initiated any time, day or night, whenever needed, without fear of incapacitating side effects.

Tedral provides:

theophylline	2 gr.
ephedrine	3/8 gr.
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in boxes of 24, 120 and 1000 tablets	

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NEW YORK

THE TRUTH ABOUT FROZEN ORANGE JUICE

Significant Dietary Advantages Of Fresh-Frozen Minute Maid Orange Juice Over Home-Squeezed Orange Juice Shown By Independent Research

RECENT assays¹ emphasize the nutritional superiority of reconstituted Minute Maid Fresh-Frozen Orange Juice over home-squeezed orange juice in three respects:

- a. Average levels of natural ascorbic acid were significantly *higher* in Minute Maid;
- b. Peel oil content was significantly *lower*;
- c. Bacterial counts were dramatically *lower*.

Two reasons for Minute Maid's higher ascorbic acid content are advanced:

First, oranges vary widely in ascorbic acid content.² Thus, whole oranges squeezed a few at a time provide a highly erratic source of Vitamin C. Each can of Minute Maid, however, represents the pooling of juice from hundreds of thousands of oranges; thus wide variations in nutrients tend to be eliminated.

Second, because it is frozen, Minute Maid loses none of its ascorbic acid content before reaching the consumer.³ Whole fruit, however, is subjected to variations in temperature, and care in handling cannot be maintained from tree

to table. Laboratory tests have shown average ascorbic acid loss of 10.7% in whole oranges after 11 days under simulated storage and shipping conditions.

Peel oil, cause of allergic responses and poor tolerance, especially in infants, is held to an arbitrary minimum in Minute Maid. Samples of home-squeezed juice expressed by typical housewives show peel oil contents up to 700% higher.

Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed samples—but were uniformly low in Minute Maid. Technicians ascribe this to the combination of rigid sanitary controls in the Minute Maid process and the low pH and low temperatures at which the juice is kept. High bacterial counts in home-squeezed juice are doubtless due to contamination from the exterior peel which is unknowingly added to the juice during preparation.

In view of the above findings, more and more physicians now specify Minute Maid Fresh-Frozen Orange Juice in lieu of home-squeezed orange juice.

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- (4) Jeulin, C. L., and Braden, H. E., *Journal of Pediatrics*, Vol. 39, No. 3, pp. 125-128 (1951).



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Wallace R. Roy, Ph.D., Director of Research

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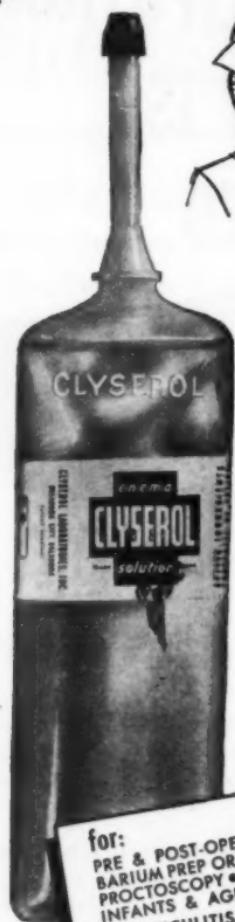
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CLYSEROL 5-MINUTE ENEMA SOLUTION,
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CANNOT HARM OR IRRITATE MEMBRANES,
cannot cause inflammation or toxicity or disturb digestion. This mild solution is non-absorptive and does not interfere with acid base or fluid balance, it evacuates the lower bowel quickly and without undesirable symptoms or discomfort.

TAKES ONLY MINUTES TO ADMINISTER

—usually about five minutes, instead of the usual thirty to forty-five minutes for the average high-fluid enema; an advantage for patient and nurse alike.

DISPOSABLE PLASTIC CONTAINER

is used for only one patient, then discarded; no cleaning-up, no sterilizing before or after administration. May be kept indefinitely without deterioration of solution or container.

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EVER SINCE physicians and hospital executives discovered eighteen years ago that Dermassage was doing a consistently good job of helping to prevent bed sores and keep patients comfortable, lotion type body lotions of similar appearance have been offered in increasing numbers.

But how many professional people would choose any product for patient care on the basis of appearance?

DERMASSAGE protects the patient's skin effectively and aids in massage because it contains the ingredients to do the job.

It contains, for instance: LANOLIN and OLIVE OIL—enough to soothe and soften dry, sheet-burned skin; MENTHOL—enough of the genuine Camphor crystals to ease ordinary itching and irritation and leave a cooling residue; germicidal HEXACHLOROPHENONE—enough to minimize risk of initial infection, give added protection where skin breaks occur despite precautions. With such a formula and a widespread reputation for silencing complaints of bed-tired backs, sore knees and elbows, Dermassage continues to justify the confidence of its many friends in the medical profession.

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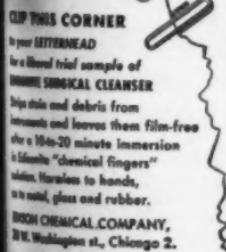
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Have you tried PENTIDS in the more common bacterial respiratory infections?

"PENICILLIN . . . first line of defense against most common bacterial infections"

Just 1 or 2 Pentids Tablets t.i.d. are particularly effective against the more common bacterial respiratory infections . . . convenient, easy-to-take . . . cause fewer side effects . . . and are less than $\frac{1}{2}$ the cost of the newer antibiotics.

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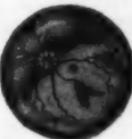
Normal. Capillaries clearly defined; no transudation, hemorrhage, or papilledema.



Borderline. Capillaries show irregularities, slight transudation. Incipient papilledema.



Abnormal. Capillaries tortuous, with areas of hemorrhage and transudation. Papilledema.



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Whenever aminophylline and phenobarbital are indicated...

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Iron deficiency anemia, "probably the commonest nutritional deficiency disease,"¹ occurs frequently in infants and children, particularly during periods of rapid growth.^{2,3}

A specific response is obtained in these cases with the use of Fer-In-Sol,[®] a concentrated solution of ferrous sulfate for convenient drop dosage. Fer-In-Sol is well tolerated, blends perfectly with fruit juices, and leaves minimum after taste.

(1) Youmans, J. B., in *Handbook of Nutrition*, Chicago, American Medical Association, 1951, p. 577; (2) Hansen, A. E., in *Mitchell-Nelson Textbook of Pediatrics*, ed. 5, Philadelphia, W. B. Saunders Co., 1950, p. 106; (3) Heck, F. J.: *J.A.M.A.* 148: 783, 1952.

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Questions

Some good ways to reciprocate

referrals • How to get delinquent accounts back on a paid-up basis • When is a doctor entitled to Social Security?

I get so many referrals and I find so few ways to reciprocate. What can you recommend my doing that I may have overlooked?

The first and best way to reciprocate is to give the patient good care, make a full report, and see that he returns to his own doctor. As obvious as this is, it's not always done.

Your report is particularly important. In most cases, an immediate telephoned report is called for; but it should be followed by a written one, too, indicating exactly what you've found and done. The referring physician who discovers your written report on his desk the next day is bound to be pleased and impressed.

Of course, a specialist can often reciprocate *in kind*—by referring patients to other physicians who have referred patients to him. To this end, a number of doctors keep track of referrals "to" and "from" in a double-entry ledger; and they try to balance the two columns.

But balancing referrals isn't always possible. In that event, you may want to show some other cour-

tesy to a referring colleague—such as inviting him out for an afternoon of golf or for dinner and a show.

Don't forget, lastly, that little gestures often count for a great deal. You may, for example, make a point of saying something complimentary to the patient about the doctor who sent him. This will make the patient feel good about having chosen such an excellent man. And if the compliment finds its way back to the referring physician—as it well may—it will please him, too.

Having neglected collections, I now find some patients owe me as much as \$400. What's a good way to get such accounts back on a paid-up basis?

Installment payments are one of the best ways of wiping out old accounts—including some you may be tempted to think of as hopeless.

Start by having your secretary prepare an itemized statement of each delinquent account, listing all visits and services not yet paid for. Then tell your debtor patients something like this:

[MORE→]

in ARTHRITIS and allied disorders

BUTAZOLIDIN

rehabilitates the disabled patient

Through the use of BUTAZOLIDIN, many patients formerly bedridden, are now able to resume an active and useful life.

A totally new, synthetic compound, BUTAZOLIDIN (brand of phenylbutazone) is not related to the steroid hormones and its therapeutic effects are not dependent upon alteration of hormonal balance.

Clinically, BUTAZOLIDIN affords relief of pain, ranging from mild to complete, in approximately 75 per cent of cases. In the majority of instances, BUTAZOLIDIN also produces increased ease and range of motion through diminution of swelling and spasticity.

Characteristically effective in almost all forms of arthritis as well as in other painful musculoskeletal disorders, BUTAZOLIDIN affords the convenience of oral administration and the economy of relatively low cost.

Rheumatoid Arthritis^{1,4}

Osteoarthritis^{1,3,5}

Ankylosing Spondylitis^{1,3,5}

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Calcific Tendinitis³

Reflex dystrophy³

Menopausal arthralgia³

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Still's disease⁵

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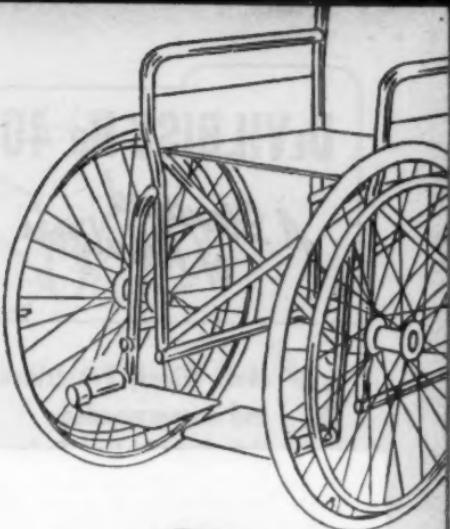
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BUTAZOLIDIN has been reported to produce favorable results in all of the listed indications.

Treatment of the more transient conditions may be discontinued a few days after symptoms have been completely relieved. In the more chronic disorders BUTAZOLIDIN is usually continued indefinitely at the minimal effective dosage level required to avoid relapse. Frequently, the initial dosage of 600-800 mg. daily may be reduced to 400 mg. daily, or even less, without loss of effect.

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The DeVilbiss No. 40 is used by more patients than any other nebulizer. DeVilbiss has been successful in creating a nebulizer that meets all medical specifications governing correct particle size and adequate volume of delivery, yet the price to the patient is just three dollars! (Slightly higher in Canada.) The No. 40 is specified for use with:

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ATOMIZERS

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QUESTIONS

"In looking over my books, I've noticed a growing accumulation of charges to your account. I haven't wanted to bombard you with bills. At the same time, I don't want you worrying about what you owe. So suppose we talk this over before the account gets any bigger."

Your approach, of course, contains no hint of doubt as to the patient's willingness to pay. In showing him the itemized statement and asking him what he feels he can do about it, you're simply suggesting that he join forces with you. The assumption is that together you'll find a way out of the difficulty.

Often, the patient will answer that he can't possibly pay the full amount immediately. That's your cue to suggest installment payments.

"Suppose I carry this on my books a little longer," you say, "with the understanding that you'll take care of it a little at a time. What do you think you could pay each month or week?" (Some practitioners avoid terms like "installments" or "time payments" in the belief that they're too commercial sounding.)

When the patient names an amount he can pay periodically, the doctor may give him a little, printed, payment-record booklet. Some practitioners feel that the use of such a booklet is a bit too commercial. Others deny this, saying that it helps to impress the debt on the patient and to remind him of payments due.

[CONT'D]

How hexachlorophene in Dial Soap can protect you and your patients!

Medical research has demonstrated the remarkable antiseptic qualities of hexachlorophene soaps. Dial was the first hexachlorophene soap to win wide public acceptance. People have been delighted to find that an antiseptic soap could be so mild, fragrant and rich-lathering. Many doctors are recommending the protective benefits of Dial Soap for patient use in both homes and hospitals.

• Reduces skin bacteria count as much as 95% when used regularly—reduces chance of infection following skin abrasions and scratches.

• Protects infants' skin—helps prevent impetigo, diaper and heat rashes, raw buttocks; stops nursery odor of diapers, rubber pants, etc.

• Stops perspiratory odors—prevents the bacterial decomposition of perspiration, which is known to be the chief cause of odor.

• Helps skin disorders—destroys bacteria which often spread and aggravate troublesome pimples and surface blemishes.

You can safely recommend Dial Soap. Under normal conditions Dial is non-toxic, non-irritating, non-sensitizing.



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QUESTIONS

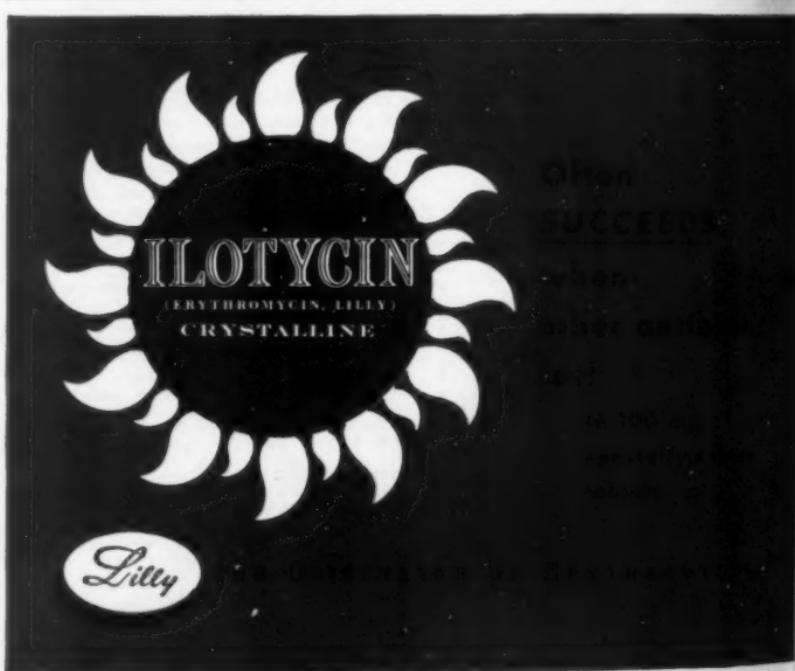
One physician who holds the latter view gives each installment-paying patient a booklet in the form of a 4" x 5" folded card. On page 1 are printed the words, "Payment Record of _____." In the blank space, the patient's name is written. The doctor's name, address, and phone number are printed below. Pages 2 and 3 are made up of columns of spaces headed "Amount Due," "Date Due," "Amount Paid," and "Balance Due." The doctor's secretary fills in the appropriate figures whenever the patient makes a payment on account.

Medical men who use such cards say they show the patient that the doctor means business, but they do

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What if a patient defaults after paying one or more installments? A procedure often recommended is to write him the day following the default and simply call it to his attention. That may be enough in itself. If not, you can suggest that the patient call at your office to work out a payment schedule better suited to his convenience.

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Shaw, H. N.; Henriksen, E.; Kessel, J. F.
and Thompson, C. F. Clinical and Laboratory Evaluation of "Vagisal" in the Treatment of Trichomonas Vaginalis Vaginitis, Western J. of Surg., Obst. & Gynec. 60:563 (Nov.) 1952.



Plus a 98% cure rate

In a recently reported study,* 100 patients with proved trichomonas vaginitis were given 36 Vagisol Suppositabs (tablet-shaped suppositories), with instructions to insert one each morning and night well up into the vaginal vault, regardless of intervening menstruation.

In the control group, 40 patients were treated with another widely used medication.

All patients, subjects as well as controls, were asked to return after 3 weeks. Effect of medication was checked by every accepted laboratory procedure, including parasitologic culture. If the patient was found negative by all methods used, complete biweekly rechecks were done over a period of 10 weeks, before she was discharged as cured.

The remarkable superiority of Vagisol was demonstrated by these significant findings:

A 98% cure rate (98 out of 100) in the Vagisol treated group.

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Under Vagisol therapy patients were symptom-free after 2.15 mean patient days. For the control group, 6.75 mean patient days were required to render them symptom-free.

72% of the patients in the study group were cured in 18 days, 22% in 36 days, 4% in 54 days. In the control group 25% required 56 days of therapy, 42.5% 84 days, and 20% required 112 days for culture-demonstrable cure.

The desirable clinical behavior of Vagisol is due to the powerful antibacterial and antiparasitic actions of phenylmercuric acetate and tyrothricin, the digestant action of papain, the surface activity of sodium lauryl sulfate, and the pH reducing influence of lactose and succinic acid.

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Sodium Lauryl Sulfate..	3.0 mg.
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VAGISOL

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QUESTIONS

the doctor set his fee too high in the first place. It's apt to suggest incompetence, carelessness, or an original desire to gouge—rather than simple humanitarianism.

Under what conditions, precisely, is a doctor covered by Social Security?

When he's employed by a company or medical group or other organization that determines the time, place, and manner in which his services are performed.

A good example is found in a ruling of the Bureau of Internal Revenue: Five physicians were associated with a certain clinic. The clinic was run as a partnership by three other physicians. The five associates were classified for Social Security purposes as employees.

Here's why:

¶ The doctors were expected to devote full time to the practice of medicine at the clinic, and not to engage in outside work for gain;

¶ The clinic provided them with quarters, supplies, and facilities, and required them to observe regular office hours;

¶ The three operating partners could direct them to handle specific types of work, as needed—e.g., general surgery or anesthesia;

¶ The partners alone owned the premises, equipment, library, and good will of the clinic; and they assumed all its financial obligations.

While the associates were thus

classified as employees, the partners were judged to be self-employed. As such, their income was not subject to Social Security taxes.

What happens if a medical group incorporates? Then *all* physicians associated with it are regarded as employes of the corporation and are subject to Social Security taxes.

In some states, of course, it's illegal for doctors to practice medicine as a corporation. But they *may* form a corporation to own a building and equipment, borrow money, or transact other business. If they do that, their joint medical practice must be carried on as a group, partnership, or voluntary association enterprise. Then, only the physicians *employed* by such an enterprise come under Social Security.

A medical *consultant* to a business firm is usually excluded from coverage. Reason: He, too, is generally an independent contractor; he's seldom required to work specific hours or follow a fixed routine. In short, his client doesn't control the way he works.

Of course, if a medical consultant is paid on an hourly, daily, weekly, or other regular basis—and if his employer does control his working conditions—then the doctor is considered an employee and is covered.

Still in doubt about your status? Then write to the Commissioner of Internal Revenue, Treasury Department, Washington 25, D.C. Explain the circumstances of your case fully and ask for a special ruling.

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**"diabetes is perhaps
the most striking
penalty of
overweight."**

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to detect urine-sugar

references

1. Statistical Bulletin, Metropolitan Life Insurance Company 33:3, 1952.
2. Editorial: *J.A.M.A.* 148:206, 1952.
3. Chapman, A. L.: Federal Security Agency, Public Health Reports 66:725, 1951.
4. Armstrong, D. B.; Dublin, L. I.; Wheatley, G. M., and Marks, H. H.: *J.A.M.A.* 147:1007, 1951.
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logically suspected

Diabetes and obesity are closely linked together.^{2,3} More than 8 out of 10 diabetics are overweight before the onset of their disease.^{1,4,5} "In persons with nondiabetic glycosuria . . . the frequency of subsequent diabetes [is] four times as high in overweight patients."⁴ "Of the major diseases, diabetes [in overweight individuals] showed relatively the greatest excess mortality — more than three times the expected number in each sex."⁶ It is logical, therefore, to suspect — and test — all overweight patients.

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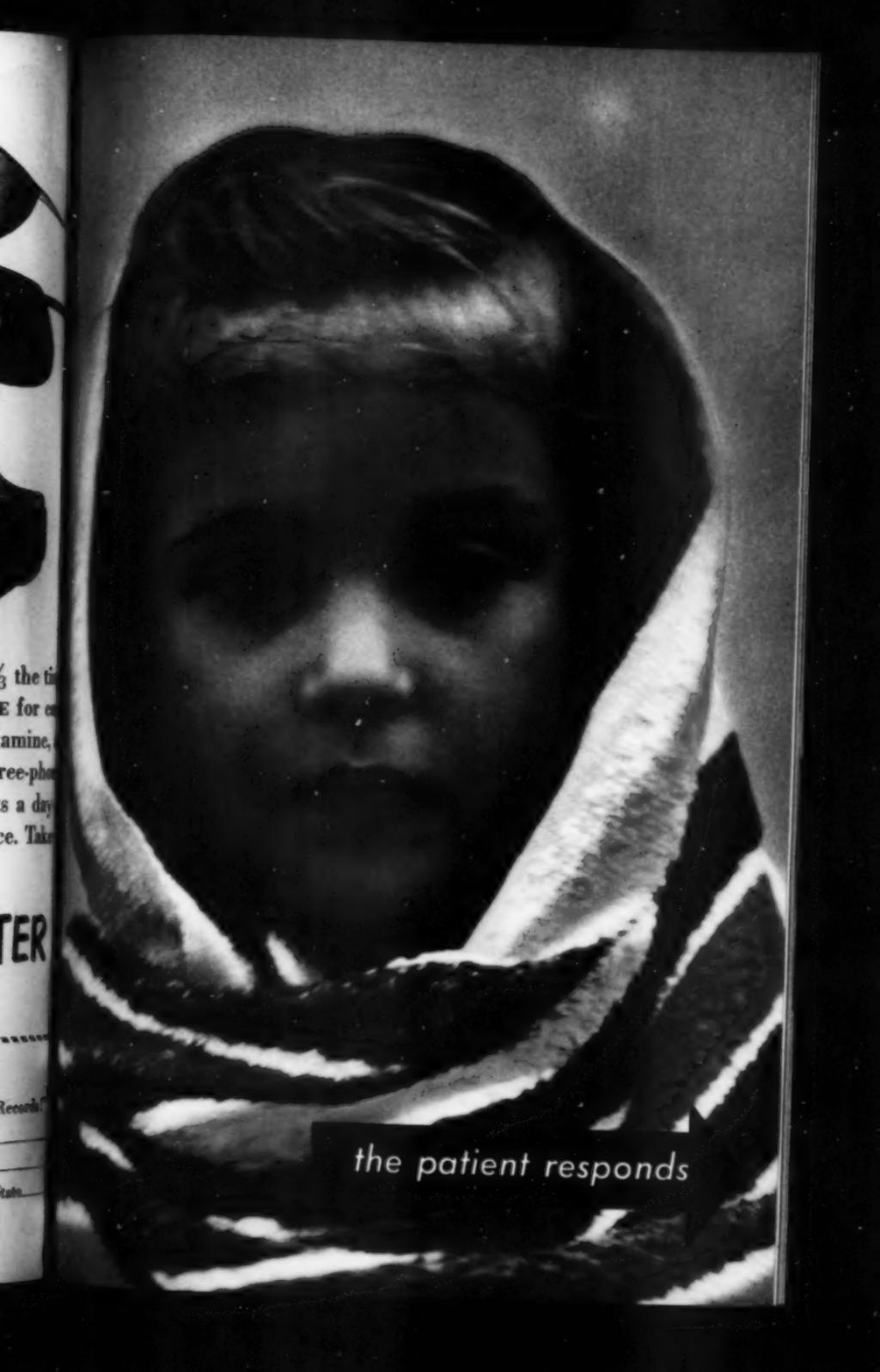
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"IPC" Penicillin Treated (21% were severe)	0%	3%	
"IPC" Treated (24% were severe)	0%	6%	

*From Edmonson, L.A. J.A.M.A., Vol. 212, No. 10, p. 2009 (June 1962).

•Percentage of end of 72 hour treatment cured.

•Success rate 100% with other symptoms of acute upper respiratory infection.

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A-P-Cillin

A recent clinical evaluation* of the effectiveness of certain drug combinations in acute upper respiratory infections, including the "common cold," clearly demonstrated A-P-Cillin to be, by far, the superior preparation.

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Wiley Laboratories, Inc., Kenilworth, N. J.

*Kane & A.: Clinical Evaluation of Combined Drug Therapy in Acute Upper Respiratory Infections, J. M. Soc. N. J. 49:509 (Dec.) 1952.

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*Milk prices cited from U. S. Bureau of Labor Statistics Bulletins.

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Oster, K. A., and Golden, M. J.:
Exp. Med. & Surg., 7:37, 1949
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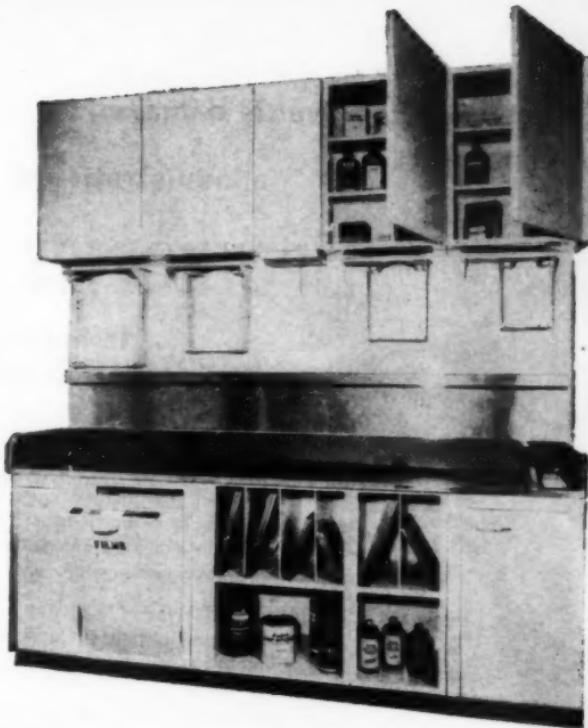
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LAKESIDE LIPOTROPICS...three forms for optimal dosage and individualized therapy

1. Pollak, O. J.: Delaware State M. J. 24:157, 1952.
2. Zelman, S.: Arch. Int. Med. 90:141, 1952.

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Medical Economics

APRIL 1953 • VOLUME 30 • NUMBER 7

Editorial

Self-Interest First

- The physician's first responsibility is not to his profession. It's not even to his patients.

It's to *himself*.

No, we're not going philosophic on you. We're thinking in very practical terms. And we recommend the same kind of thinking to many another physician.

Take, for example, Dr. A. He runs a large practice single-handed. Or, rather, his practice runs *him*. His office is swarming with patients from early morning until 10 or 11 at night. He's dedicated himself to answering every last one of their demands, and the pace is quite literally killing him. He had his first coronary three months ago, at the age of 49.

Dr. B's dedication takes a somewhat different form. Although he works on a regular schedule, he prides himself on never having taken time off since World War II. "My patients can't spare me," he believes. Unfortunately, the lack of vacations has dulled his zest; the lack of refresher training has dulled his competence. The word is now going around that he "used to be a better doctor than he is."

Dr. C, by contrast, is an up-to-the-minute diagnostician. But since he doesn't believe in pressing patients for payment, he collects scarcely two-thirds of his accounts. He's never felt affluent enough to invest in all the equipment and assistants he really needs. So he's limited in what he can do; and, as a result, he gets fewer referrals than he should.

Now think, for a moment, about these three colleagues of ours. Each one is motivated by the prime object of the medi-

EDITORIAL

sion: "to render service to humanity." Yet a dead doctor can't render any sort of service; and an out-of-date doctor or a poorly equipped one usually gives inferior care.

Is this what people really want? Obviously not. To provide the best possible service over the longest possible period, a physician *has* to think of himself.

He must set a reasonable schedule and then—except in real emergencies—stick to it. He must get away from his practice from time to time. He must surround himself with the tools and the aides that can make his task easier. And he must be sufficiently businesslike to acquire the necessary capital.

Call it enlightened self-interest if you want. It's still the best way we know for a physician to provide the best medical care.

Don't Write; Telephone

When, in the public press, an attack is made on the competence, honesty, or public spirit of physicians, a fast retort from the doctors can generally clarify the situation. Yet many medical societies insist that official opinion be expressed through some official channel at a later date.

Most societies, indeed, are proud of the fact that no one officer can speak for all his colleagues. And that's a fine, democratic idea. But it often means abandoning the forum to medicine's critics.

We've just heard, though, of an

interesting solution to this problem. One society we know of has named a panel of five officers. And it has empowered any one of these to speak for local doctors in any emergency, provided he gets telephone approval of his remarks from two of his fellow panel-members.

We like that idea. For as long as medicine is fair game for scandalmongers, swift counteraction is often the only effective antidote.

Why Groups Fail

If an organism serves a real need, it will flourish. If it doesn't, it will atrophy. That's the law of nature—and the law of group practice.

Of the medical groups functioning a decade ago, about 20 per cent no longer exist today. At least that's what a recent A.M.A. study shows. And although these groups may have foundered from internal causes, as the A.M.A. suggests, don't overlook the possibility of external causes too.

Why does a group prosper in one community while an equally competent group withers and dies in another? The answer usually lies in the town. Suppose it already has a good supply of specialists, of diagnostic facilities. What real need can a new group fill?

Some doctors, apparently, still ignore this question. The groups they form—like the brachial clefts—may be destined to atrophy quietly away. —H. SHERIDAN BAKETEL, M.D.

A Scientific Yardstick For Setting Fees

How one physician has tried to make sense out of surgical fees by setting a value for each operation in relation to the others

By Mauri Edwards

• A surgeon in an Eastern city may charge \$240 for a cholecystectomy and \$30 for a child's T. & A. Yet in a comparable Midwestern city these same operations generally cost, respectively, \$150 and \$75.

Such inconsistency confuses the public badly. And the confusion is growing; for, as one physician notes, "The increasing use of rate schedules by health insurance and compensation agencies brings clearly into focus the startling and undesirable variation in fees charged for medical and surgical procedures."

So says Dr. William H. Horton, director of medical services of the Connecticut Medical Service, Inc.

Dr. Horton makes no issue of the \$90 difference between the two cholecystectomy fees cited or of the \$45 gap between the two T. & A. charges. For any of a dozen different economic factors can force surgical fees up in one area, keep them down in another.

What he does say is that *the relationship between the values of any two operations is constant*. Therefore, the relationship between the



Dr. Horton

A SCIENTIFIC YARDSTICK FOR FEES

fees for those operations should also be constant.

Like a sore thumb, he says, is the fact that in one city the charge for a cholecystectomy may be eight times as much as for a child's T. & A., while in another city the going ratio is two to one. Whatever the proper ratio, he emphasizes, it ought to be the same everywhere.

All right, then. But can anything be done about the situation as it now exists?

Horton's answer: yes. He began, in fact, to tackle it some time ago.

One of his first conclusions was that the answer did not lie simply in more fee schedules. The thing that doctors really needed, he felt, was a yardstick—"a better basis on which fee schedules could be constructed." So he determined to seek that "better basis."

Finding a Gauge

First, he limited his study to surgical specialties because "they lend themselves most easily to classification." Then he singled out what he regarded as the three key elements that enter into any surgical procedure: technical skill, duration of the operation, and amount of after-care.

He acknowledged that it wasn't possible to put price tags on the three elements he'd picked out. But he did believe that they could be given *relative values*.

So he prepared a questionnaire and sent it to sixty Connecticut phy-

sicians. He asked them to rate each of about twenty-five operations in terms of the three elements; and he stressed the need for objectivity.

Forty-seven physicians replied. Horton studied their answers. He refined his questions. Then he tried a second mailing.

This time he sent questionnaires to all practicing M.D.'s in Connecticut and to a sprinkling of doctors in near-by states. He got 740 replies or better than a 30 per cent response. From these, he compiled what he now calls "a preliminary index of surgical ratios."

Three Basic Elements

To understand how Horton arrived at the figures in the accompanying table, suppose that you're a Connecticut doctor and you've just received one of his questionnaires. Among the operations you're asked to evaluate is a colon resection. So you ask yourself:

1. *How much technical skill does the operation require?* Horton lists four gradations: minimum skill, worth one point; average skill, two points; advanced skill, three points; and maximum skill, four points.

You probably feel, as most of the physicians queried felt, that a colon resection demands maximum skill. So you give it four points.

2. *How long is the operation likely to take?* For a surgical procedure lasting up to half an hour, Horton allows one point; for up to an hour, two points; for up to two hours,

A SCIENTIFIC YARDSTICK FOR FEES

Professional Services Index

(Developed by William H. Horton, M.D.)

<i>Operation</i>	<i>Rating</i>
Appendectomy	12
Cholecystectomy	18
Colles fracture, closed reduction	9
Colon resection	23
Craniotomy, for tumor or abscess	27
Cystoscopy with ureteral catheterization	4
Dilatation/curettage	3
Extraction of cataract lens	14
Fractured femur, closed reduction	11
Fractured femur, open reduction	17
Fractured metatarsal, closed reduction	9
Gastrectomy, total	23
Hemorrhoidectomy, internal and external	10
Herniorrhaphy, inguinal, bilateral	12
Herniorrhaphy, inguinal, unilateral	10
Hysterectomy, abdominal, total	18
Mastectomy, radical	19
Mastectomy, simple	10
Nephrectomy	18
Prostatectomy, suprapubic	18
Prostatectomy, transurethral	17
Sub-mucous resection	10
Tonsillectomy/adenoideectomy, child	6
Varicose veins, bilateral	11
Varicose veins, unilateral	10

A SCIENTIFIC YARDSTICK FOR FEES

three points; and for any longer period, four points.

A colon resection is apt to last for more than two hours. So you give it four points. And that's the figure put down by most of the doctors questioned.

3. *How much aftercare will the patient probably need?* For a procedure requiring less than twenty-four hours' postoperative care, Horton makes no allowance at all. For two-to-three days' probable care, he allows one point; for four-to-ten days, two points; for eleven-to-thirty days, three points; for up to ninety days, four points; and for still longer periods, five points.

If you're like the average respondent to the Horton survey, your estimate of aftercare in the case of a colon resection is between eleven and thirty days. So here you put down three points.



In rating the various surgical procedures, Dr. Horton believed it necessary to take into account not only the three factors about which he had asked the opinions of physicians in his state but also two factors that he felt weren't subject to opinion. For this reason, he alone evaluated the surgical operations in terms of the final two factors.

Other Ingredients

He calls the first of these two factors "the surgical field," meaning generally, the anatomical location of the operation. In terms of this factor, he rates operations from zero to two points.¹ His evaluation of a colon resection is two points.

Horton calls the second non-discretionary factor the "surgical problem," and it deals with the type and difficulty of the operation. The point range here is from one to three.² Horton grades a colon resection at two.

Finally, by means of a simple formula, Horton integrated his non-dis-

¹Horton's "surgical-field" ratings are, more specifically, as follows: No points for instrumentation not requiring an approach by cutting surgery. One point for superficial lesions, lacerations, or wounds; for external organs or tissues; for cavities opening externally, directly or indirectly; or for extremities. Two points for internal organs or tissues.

²The "surgical-problem" ratings, in more detail: One point for a simple incision, excision, or repair; for a closed reduction of a fracture; or for manipulative endoscopy. Two points for an extensive excision, dissection, or repair; for an open reduction of a fracture; or for operative endoscopy. Three points for a radical excision or dissection for malignancy; or for a ruptured organ.

A SCIENTIFIC YARDSTICK FOR FEES

retionary ratings with the answers submitted by his respondents.* Result: the Professional Services Index shown on page 103.

You'll notice that the index rating of a colon resection turns out to be 22. It's almost at the top of the list. Only a craniotomy, rated at 27, ranks higher. At the bottom of the index is a low 3, for a D. & C.

Relative Values

Now, with the index in mind, let's return to the example cited earlier. Was the Eastern city's eight-to-one ratio between a cholecystectomy and a child's T. & A. in line with the Connecticut survey? Or was the Midwestern city's two-to-one ratio more realistic?

The Professional Services Index rates the gall bladder operation at 18, the child's T. & A. at 6. So the ratio is three to one. And that's what it probably *should* be—if the index is valid.

It's been noted that Horton's ratings are relative, that he neither

sought nor wanted to arrive at a single, nation-wide schedule of fees. Yet his index is easily translated into dollars and cents. If, for example, a surgeon charges \$100 for an appendectomy (index rating, 12), then his fee for a hysterectomy (index rating, 18) may well be \$150.

On the Chin

Horton expects some doctors to regard his index as too arbitrary. He expects criticism because he didn't limit his survey of surgical procedures to surgeons but questioned other practitioners as well.

As a matter of fact, some of the M.D.'s who took part in the survey expressed their misgivings about it at that time.

"This evaluation seems pointless to me," said one "—especially in those subjects outside my field." Added another: "Only those actually engaged in a specialty are qualified to appraise its procedures."

The Other Side

But Dr. Horton disagrees. Even if G.P.'s, obstetricians, and urologists aren't familiar with every detail of a radical mastectomy, for example, "they can still evaluate it in relation to other procedures with which they are familiar," he says.

And, he goes on, "since all physicians' fees bear a relationship to each other, we can minimize arbitrariness by basing them on the average opinion of the profession as a whole."

[MORE ON 229]

*Substituting the letters Sf for surgical field, Ts for surgical problem, Ts for technical skill required, Ac for aftercare, and Do for duration of the operation, here is the Horton formula:

Sf + Ts + Ac + Do = Index Rating

In explanation, Horton says that he adds the two nondiscretionary factors—surgical field and surgical problem—so as to "create a figure proportional to the relative magnitude of the operation."

He then multiplies the total by the rating assigned to technical skill. This gives a figure that expresses "the amount of the surgeon's skill needed to perform the operation." It gives less weight to the last two factors (duration and duration of the operation)—by only adding their points to the total.



They Risked Loss of Dignity... and

● Is it poor taste for physicians to engage in novel publicity stunts—even when their aim is to raise funds for community projects?

This became a practical question, not long ago, in Ballard, Wash., a suburb of Seattle.

Ballard wanted a new general hospital. It had a \$600,000 Federal grant; but it needed to raise another \$900,000. Its campaign for public support, run along orthodox lines for three months, had fallen far short of the target.

So the campaigners hired a professional publicity man.

Immediately the drive shed its conservatism. Gags and stunts became the order of the day. And the chief

ANGLE ASSUMED by Dr. Charles Day is to pay bet that Ballard's \$900,000 hospital drive would flop. It didn't; so Dr. Christian Melgard directs Day—and golfball—across the main street.

POSITION TAKEN by Dr. J. H. Lehmann is to help pajama-clad William Jones sign a \$2,100-pledge. Stunts of this sort put over the big fund drive.

When their campaign for funds stalled, these doctors turned stunt men. Result: some criticism—but success



Dignified and Gained a Hospital

stunt men were (of all people) Ballard's physicians.

To focus attention on the hospital problem, the publicist and the medical men collaborated on such schemes as a Western parade, the dunking of a business man "who refused to contribute," and sundry other spectacular devices for dramatizing the campaign. The most successful of these was also the most controversial:

To show the need for a new hospital, the campaigners decided to stress the poor location and meager facilities of the old one (a thirty-five-bed affair located on the third floor of an office building). They hit on the idea of dramatically reversing a medical [MORE TEXT ON 110]



BIGGEST STUNT gets started as physicians Lehmann, Edward Pal-mason, Day, and Paul Johnson rouse Ballard's citizenry at mid-night, citing an "emergency." The crowd gathers at the old hospital and watches a mock operation. There's a real operation, too —extracting money from the townspeople for the new hospital.

MAKE YOUR PLEDGE





ANGRY TORRENT of words is Harvey Lewinson's reaction to the midnight oil. Later, though, he cooled off; it was a worth-while cause, he decided.

KIOSK AND BUGGY doctor Ralph Gregg—in another fund-raising stunt emphasizes that Ballard's needs have grown the old 35-bed institution.

CHEEK OPERATION, performed by a surgical nurse, Mrs. Evelyn Clute, is Kiert Smith's receipt for the \$3,000 he has just donated to the hospital.

LADY GODIVA, too, helps out. An earlier Godiva sacrificed dignity for the good of her town. And this one helps Ballard build a new hospital.

THEY RISKED LOSS OF DIGNITY

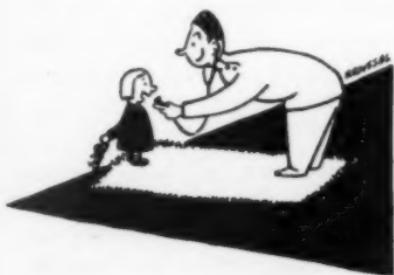
tradition: the late-night emergency call. Why not, they thought, have the *doctor* phone the *patient* for once?

Sleepy Town Roused

At the witching hour on a Saturday night, ten physicians grouped themselves at a battery of telephones and—patient lists in hand—rattled off fifty calls apiece. In tense voices they said to patient after patient: "We have an emergency at Ballard Hospital. Will you please come right down and help us do something about this sick hospital situation?"

At the other end of the wires, sleepy ears were shocked to attention. Some people doubtless refused to bite; but more than 300 others jumped out of bed and rushed to the rescue. Many of them apparently believed that this was an urgent summons to action in a disaster—perhaps even an attack.

Outside, in the streets of Ballard, ambulances, fire engines, and police cars raced through the darkness, their sirens howling. Says one of the physicians who participated in the stunt: "It sounded like the end of



the world, or at least of Ballard."

Moments later, dozens of automobiles converged on the building that housed Ballard's old hospital. Many of the drivers were still in disarray, still poking sleep from their eyes.

'Just Sign Here'

At the entrance to the hospital, Ballard's citizenry found out what they'd been called up for: not a catastrophe, but a demonstration of how neat and efficient a new operating theatre would be; no disaster victims, but filled fountain pens and an ample supply of pledge blanks.

The reaction to all this? Some people evidently resented being taken in by a publicity trick. But many others gladly signed on the dotted line.

Says one of the campaign's main plugs, Dr. J. H. Lehmann: "Although there were some adverse repercussions from the public as well as from some of the medical authorities, this stunt seemed to wake up the community."

The community was, in fact, wakened up figuratively as well as literally. From that point on, the campaign for hospital funds swept surely toward the \$900,000 mark.

True, not all Ballard doctors were entirely happy about the situation. Some of their patients felt imposed upon or shocked by their physicians' capers.

But none could deny the payoff. For the town will now have a fine, new hospital.

KND

Physicians May Scrap Service-Type Health Plan

Sweeping changes are being proposed in the country's original Blue Shield plan. A switch to indemnity benefits, the use of average-fee lists—these and other proposals will be voted on next month. Here are the significant details

By Wallace Croatman

- How can a voluntary health insurance plan adequately protect subscribers without usurping the physician's right to set his own fees?

This dilemma has long plagued just about every physician-sponsored prepay plan. A fresh effort to solve it is now being made in California, where a special committee of fifteen medical leaders recently wound up an eighteen-month investigation of their Blue Shield plan—California Physicians' Service.

The committee recommends a so-called "average-fee plan" to replace the present set-up. The proposal will be up for final approval at next month's meeting of the California Medical Association's House of Delegates. It may eventually affect prepay plans everywhere.

Briefly, the plan is designed to put more emphasis on indemnity insurance, less on service-type coverage. If it takes hold, all C.P.S. contracts may eventually be of the indemnity type.

The change to indemnity insurance would probably please a good many doctors, who'd have greater freedom

PHYSICIANS MAY SCRAP SERVICE-TYPE PLAN

to set their own fees under such a plan than under the existing service agreement. But what about patients?

The committee concedes that they're likely to prefer a service plan—unless they're assured that indemnity payments will be high enough to approximate average doctor bills.

Accent on Average Fees

In other words, the committee thinks that indemnity insurance can be made palatable to the public if a way is found to keep indemnities abreast of prevailing charges for medical services. It proposes to do this through a system of average-fee schedules.

Here's how the plan will work, if adopted:

Each doctor will be asked to establish his own fee schedule and post it with his county society. Each county will then compile a list of average fees; and from these averages the C.M.A. will draw up a statewide fee schedule. Both county and state lists will be revised annually.

Must the individual doctor adhere to the average-fee list? No. *But if in some instances he wants to charge more than his usual fee, he'll be expected to work out an understanding with the patient in advance.*

Higher Indemnities Sought

The county and state lists, then, won't necessarily regulate the individual doctor's fee. Here's what they *will* accomplish:

For one thing, they'll provide in-

surance companies (commercial ones as well as the C.P.S.) with realistic averages for use in drawing up indemnity schedules. And, for another thing, they'll give prospective subscribers a line on the adequacy of insurance indemnities.

But the public will be warned that the listed averages won't apply to every doctor—that they are, in fact, only average fees for the average patient of the average doctor.

Will this make the plan unsatisfactory to patients? The committee thinks not. As Rollen Waterson, executive secretary of the Alameda-Contra Costa Medical Association, puts it:

"Patients expect variations among doctors. They expect to pay more to the highly qualified specialist, to the physician whose office is in a high-rent district, or to the man with an extra-heavy investment in equipment. Some people even boast of paying a high fee."

What's New About It?

This plan isn't altogether new. It's a blend of two fairly well-known ingredients: indemnity insurance and the average-fee schedule. Yet it represents a major shift from the typical Blue Shield policy.

The present C.P.S. contract, for example, is of the common partial-service type. It offers protection, with no surcharges, to families earning less than \$4,200; but it leaves doctors free to charge more to patients with higher incomes. Except

PYHICIAN'S MAY SCRAP SERVICE-TYPE PLAN

for a few boosts in the income ceiling, this is essentially the same plan that California doctors first organized in 1939.

What makes them want to change now? A chain of events that has led them to believe their present arrangement just isn't good enough.

Fee-Fraud Disclosure

The worst black eye suffered by C.P.S. came with the disclosure a year ago that some M.D.'s were making a business of systematically billing it. Their schemes apparently ranged from overuse of the plan to billing for services never performed.

Nobody is sure how widespread such abuses have been. But the initial charge—leveled by Dr. Paul D.

Foster, a member of the committee studying C.P.S.—was that at least 200 doctors were cheating the plan out of more than \$1 million a year.

Medical leaders wasted no time in condemning such chicanery, and legal action was started against some of the wrongdoers. But few doctors believe that the situation has since been entirely cleaned up.

Damaging though they were, the fee-fraud disclosures served a useful purpose: They brought to a head some of the grievances that doctors, patients, and other interested parties have long held against the Blue Shield plan.

The main complaint of patients, as you might expect, centers about the extra charges often levied against



Bailey



Graeser



Waterson



Foster

LEADING FIGURES in the drive to revamp California's Blue Shield plan include Dr. Wilbur Bailey, who headed the committee that worked out the new "average-fee" idea; Dr. James Graeser and Rollen Waterson, the committee vice-chairman and executive secretary, respectively; and Dr. Paul Foster, whose disclosure of fee frauds a year ago pointed up the need for changes.

PHYSICIANS MAY SCRAP SERVICE-TYPE PLAN

subscribers whose incomes are slightly above the ceiling for service benefits. It's not uncommon, they say, for a physician to charge the patient his regular fee *plus* whatever the health plan provides.

As a result, more and more patients are apparently coming to believe that Blue Shield insurance isn't much good. Even when a doctor's extra charge is small, subscribers often fail to appreciate the part played by C.P.S. in meeting the over-all bill. Reason: C.P.S. checks go directly to the physician, with no accounting made to the patient.

Why Doctors Object

The typical doctor is no happier about the present set-up than is the average disgruntled patient. He objects in particular to having to accept Blue Shield's generally low allowances as full compensation from patients below the income ceiling.

In view of all this criticism, it's perhaps understandable why C.P.S. membership has suffered an alarming decline. In December, 1950, the plan had more than a million subscribers; by last June, it had lost almost a third of them. And this drop came at a time when almost every other Blue Shield plan was registering substantial gains.

Much of the decline, of course, simply reflects the stiff competition C.P.S. is getting from other health insurance plans.

One competitor, oddly enough, is the Blue Cross hospital plan in

Southern California. Once allies, Blue Cross and C.P.S. split up in August, 1950. Since then each organization has sold coverage against both hospital and doctor bills.

Then, too, there's the challenge of closed-panel plans like the Kaiser Health Foundation (better known as the Permanente Foundation). Permanente now boasts 225,000 members in California alone; it threatens to go over the 400,000 mark when new medical centers, now under way, are completed.

Labor's Health Plans

Labor has also been getting into the act: The California State Federation of Labor has unanimously adopted a resolution condemning "the widespread practice of members of the medical profession of charging excessive fees for services rendered under health and welfare plans." Meanwhile, the San Francisco Labor Council is considering an ambitious, city-wide network of labor health centers. These would be run on the order of Permanente and would be financed largely by employer contributions.

California doctors find plenty to worry about, then, in the revelation of dishonesty in their ranks, in the drop in Blue Shield membership, and in the growth of competing health plans. Nor can they be unconcerned about something else: the threat of state-wide compulsory health insurance.

It was this threat that spurred the

PHYSICIANS MAY SCRAP SERVICE-TYPE PLAN

profession into setting up C.P.S. fourteen years ago. It was a renewal of the threat, under Governor Earl Warren, that brought on a giant membership drive by C.P.S. shortly after the war. And though agitation for compulsory health insurance has lessened in recent years, it may crop up again.

Will Doctors Accept It?

So much for the background. Now let's take a closer look at the average-fee plan itself. What, to begin with, are its chances of winning widespread professional approval?

According to some medical observers, they're pretty good. Waterston, for example, says that more doctors in Alameda and Contra Costa counties seem to favor adoption; he thinks even more will be sold on the idea once they thoroughly understand it.

The plan has already been given wide-and-favorable-publicity in the lay press. The San Francisco Chronicle, for example, calls it "a revolutionary program to put the business side of medicine on a businesslike basis." After this build-up, medical men may hesitate to risk an unfavorable public reaction by turning thumbs down on the average-fee plan.

Moreover, the C.M.A. House of Delegates won't be asked to commit itself irrevocably, but only to give the average-fee plan a go ahead on a trial basis.

Explains John Hunton, executive secretary of the Association: "The indemnity program will have to stand on its own feet, with the knowledge that it may supplant the C.P.S. service program if it attracts sufficient public acceptance. Meanwhile, there will be no transfer of groups of accounts except where the insured want to be transferred."

Questions From Doctors

Whether or not the plan is approved, doctors everywhere are sure to ask plenty of questions about it. For example:

Will the "average" fees listed with county and state societies tend to become maximum fees?

Even staunch supporters of the scheme admit that the mere existence of average-fee schedules may have some leveling effect on the individual doctor's fees. At least, this has happened in other states where average-fee schedules have been tried out. Yet advocates of the plan argue that the *excessive* fee will be affected far more than the justifiably larger-than-average fee.

What about physicians who base fees largely on the patient's ability to pay?

The average-fee plan won't compel physicians to charge every patient alike for the same service. But it could signal the beginning of the end for the sliding scale.

The C.M.A. committee, by the way, leaves no doubt about its distaste for the sliding scale [MORE ON 231]

If You Need to Borrow Money

Where should you go for it? How much can you get? What collateral should you offer? What will the loan cost you? Here are the answers to all those questions—and more

By Don Cameron

- For one of a dozen reasons, you may be thinking of getting a loan. But have you given serious consideration to shopping for it?

This country is more liberally supplied with lenders of money than with doctors of medicine. "We are retailing bank service," an officer of one of the nation's largest lending institutions recently told a banking group. And like other retailers, moneylenders offer a variety of prices, services, and conveniences. As a customer, your problem is to find the combination best suited to your special need.

In shopping for a loan, it's important to keep certain basic facts of economic life in mind. Four of these—familiar as they are—deserve re-emphasis:

1. Reputable lenders are usually more interested in your earning power and past credit record than in the value of your security. What counts is your ability to *pay back* the loan. For this reason, an established physician seldom has trouble getting an unsecured loan of a reasonable amount.

2. But once you've established your pay-back ability,

*While information was drawn from many sources, this article was prepared largely with the advice and assistance of Louis J. Asterita, deputy manager of the American Bankers Association and secretary of the A.B.A.'s Installment Credit Commission.

OPEN 10:00 - 10:00
S.A.M. to 12:00
MONDAY - THURSDAY
8:00 A.M. to 12:00
FRIDAY
8:00 A.M. to 12:00
SATURDAY
8:00 A.M. to 12:00
SUNDAY
8:00 A.M. to 12:00

IF YOU NEED TO BORROW MONEY

security does matter; the better your security, the lower the interest you'll be charged. The reason is obvious: Good security reduces the lender's risk.

3. A small loan with many installment repayment dates is costlier than a larger loan paid back in a lump sum or in a few installments.

4. There's no real difference between borrowing cash and buying something on the installment plan.

But this isn't the whole story, of course. Before you do any actual borrowing, you'll want answers to such fundamental questions as:

¶ Where should you shop for a loan?

¶ How much can you borrow?

¶ What sort of collateral should you offer?

¶ What will the loan cost?

The picture isn't all of a piece from coast to coast, or even from street to street. State lending laws vary, and so do bank practices among institutions within the same town. But the following survey should give you a fair idea of what to expect.

The Loan Markets

Where should you shop for a loan? The principal credit sources are:

1. Commercial banks. These are probably your best bet for most borrowing purposes. They'll give you the largest and cheapest short-term loans commensurate with your credit rating. Many commercial banks

also operate personal loan departments that will lend you money for longer periods—often up to two years. But they're apt to have somewhat stricter credit standards than other lenders.

2. Industrial banks (including "Morris Plan" banks). These tend to make larger personal installment loans than do commercial banks in the same community. Some deal in other types of loans as well. Borrowing from industrial banks may cost more; but such banks often provide a more flexible service than their commercial neighbors.

3. Savings banks. These specialize as a rule in long-term investments in building and development projects. But in some areas they also grant personal and small-business loans.

4. Insurance companies. If you're a policyholder, the company will lend you any amount up to the cash surrender value of your policy, at 5 or 6 per cent interest (4 per cent on G.I. policies). Such a loan can run indefinitely; but this isn't necessarily an advantage; for if you give in to the temptation to let it ride, you may eventually deprive your family of needed protection.

5. The credit facilities of business houses that sell on time. If you're borrowing in order to buy something, such credit is worth considering. Admittedly, it's often cheaper to buy an expensive item by borrowing cash at the bank than by financing it through the custom-

IF YOU NEED TO BORROW MONEY

any channels. But there are some firms that make it possible for you to buy their products on installments for less than it would cost you to borrow the cash elsewhere.

There are still other sources of loans; but few of them have much to offer the doctor. The small loan companies, for example, are restricted by law to loans of \$300 or \$500, and they specialize in less desirable credit risks at high rates.

If lending facilities in your community are limited, you may find it worthwhile to shop the money market in a near-by business center.

The Top Limits

How much can you borrow?

On your good name alone, you can get up to \$10,000 (perhaps even more) from almost any commercial or industrial bank—depending on your ability to repay.

Most banks with personal loan departments like to keep loans within 10 to 20 per cent of the borrower's annual income. Usually, too, they set arbitrary top limits, such as \$2,500 to \$5,000 if the money is for personal use, and \$5,000 to \$10,000 for business purposes.

But if you have an established practice and a good credit rating—or a highly solvent co-maker—you may be able to borrow up to half the amount of your yearly income.

Most physicians, from the lender's viewpoint, are small businessmen. As a rule, banks make so-called small-business loans on the same ba-

sis as personal loans—with this exception: Since the object of a business loan is increased earnings, banks are inclined to be more liberal about such a loan (as long as the proposition seems sound) than about a personal loan.

Sound Collateral

What sort of collateral should you offer?

In addition to having an income, you also probably carry life insurance. Quite likely, too, you have money invested in stocks, bonds, and real estate. All these things are first-rate aids to borrowing.

Your insurance company or bank will lend you 95 to 100 per cent of the equity you have in your life insurance policy (though remember that, of the two, the bank will generally give you the lower interest rate). Usually the bank will also lend you 75 to 80 per cent of the stock market value of your listed securities (excluding U.S. defense bonds, which cannot be used as collateral). And, of course, if you have a savings account you'd rather not break into, your passbook is good for a loan practically to its full amount.

Lenders report that the automobile is the security most commonly pledged by applicants for all types of loans. Commercial and industrial banks will normally lend up to two-thirds of the resale value of a car not over two years old. On older models the borrowing value is proportionately less.

[MORE ON 199]

Where You'll Stand In the New Doctor Draft

Pentagon policy at the present time is to net all possible medical officers by keeping the draft age high and physical standards low

By Mauri Edwards

- On the last day of June, Public Law 779—the doctor draft—will expire, and Congress and the President will have agreed on a new measure.

Don't expect the 1953 law to be radically different from the old one. But do be prepared for some possible changes in your personal situation if you're now in Priority 3 or 4.

With the pool of Priority 1 and 2 doctors nearly exhausted, the armed forces must look elsewhere for medical men. And "elsewhere" may mean in your direction—even if you're getting on in years and are well under par physically.

If present plans go through, the word "Priority" will become obsolete in this context. The Pentagon has indicated its intention to refer to Priority 3 and 4 doctors as, respectively, First Group and Second Group—the first to consist of non-veterans, the second of veterans.

Naturally, the non-veterans will be called first, in order of age. Only when this category is exhausted will the veterans begin to go.

The Pentagon wants to avoid drafting many members of the Second Group. So it now plans to get the greatest possible number of non-veterans by:

1. Keeping the draft's maximum age at 51; and
2. Drastically reducing physical standards.

That both steps are necessary is brought home by a statistical breakdown of the 33,000 doctors who fall into the non-veteran pool. Some 10,000 of them are below 40. About 4,000 are over 50. The rest—about 19,000—lie in between.

Obviously, thousands of these men are likely to reach 51 before they can be called. So if the top age were lowered even by a couple of years, there'd be an enormous decrease in the number of non-veterans available. As a result, the Pentagon would be forced to hit the veterans' group early and hard.

[MORE→



THE NEW DOCTOR DRAFT

But a high draft age alone isn't enough to keep this from happening. Since physical standards of Selective Service are aimed at boys of 18, not men of 40, few non-veteran doctors can meet them. To date, more middle-aged M.D.'s have been classified 4F than 1A. So the military has sharply reduced its standards.

Suppose, for example, you're a non-veteran, aged 50. You used to be 4F, because you're missing an arm or a leg. No matter. When the bugle blows this time, it's for you.

It won't make much difference if you're troubled by arthritis or ulcers. Deafness won't disqualify you. Neither will asthma nor rheumatic fever. The ailments that would entitle a lad of 18 to a pass back home may get you nothing more than a "limited service" stamp on your papers.

Some Veterans, Too

With the draft age high and physical standards low, will the Pentagon then find enough medical officers among non-veterans? Probably.



IF YOU'RE CALLED UP, you may find yourself close to the front in Korea, treating the wounded. Here, [▲] Captain Paul G. Bauer of the Army Medical Corps administers blood plasma to a G.I. hit by the Reds, while Captain D. E. Hoganson [►] examines the eye of a captured Chinese Communist soldier.

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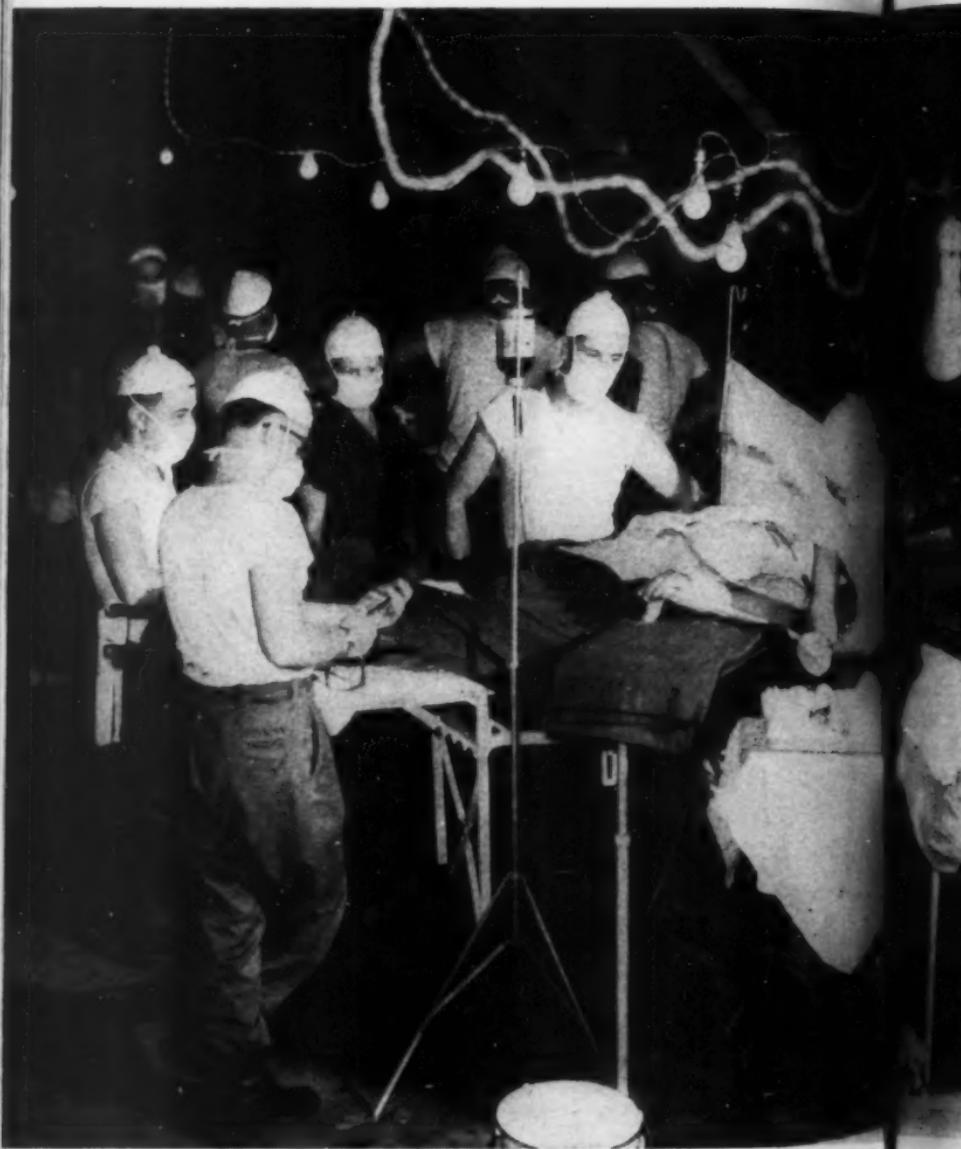
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THE NEW DOCTOR DRAFT



TWENTY MILES BACK from the guns, a surgeon is set to perform a delicate operation on a wounded soldier. The scene is the 8209th Mobile Army Surgical Hospital.

THE NEW DOCTOR DRAFT

not. It may well have to dip into the reservoir of veterans.

But it hopes to be compelled to call up only those doctors who barely slipped into this second category. In other words, some medical men who served less than two years may be drafted; those with longer hitches behind them should be reasonably safe.

Other Changes

Besides planning for the induction of non-veteran doctors, the Pentagon's Armed Forces Medical Policy Council has tried to smooth a number of lesser rough spots in the doctor draft. As a result of these efforts, the new law is likely to:

1. Credit you for wartime service you gave to an allied nation.
2. Clarify your status if you're an alien physician, to make sure you're not disqualified from service for lack of citizenship.
3. Grade and pay you in terms of your experience and ability.
4. Limit your new service to seventeen months if you've already served a year.
5. Terminate your reserve commission at the end of your tour of active duty.

What Will Congress Do?

There you have an over-all picture of what to expect. But will the new bill be enacted? The answer depends, in part, on whether the various medical organizations that testify before Congress support the

THE NEW DOCTOR DRAFT

Pentagon or attack its proposals.

In an effort to sound out such organizations, the Department of Defense called a conference in February. It disclosed its plans to the A.M.A., to hospital and educational associations, and others. Their reaction: guarded.

Said an A.M.A. spokesman, Dr. David B. Allman: "At first glance, this looks like a step in the right direction." But he added that doctors would prefer to see the draft extended for just one year (instead of two, as the Pentagon planned). And he stressed the A.M.A. feeling that the services must make maximum use of their present medical personnel.

Dr. Allman's spur-of-the-moment comments may well form the basis of a doctors' appeal to Congress. Their double argument:

1. Since the military situation may change at any time, why not write just a one-year extension of the draft?
2. Do the armed forces *really* need as many doctors as they say they do?

Doctor-Troops Ratio

This second question tests what may be the weakest link in the Pentagon's chain of logic: the assumption that the armed forces in their present size must have 13,500 medical officers.

The Pentagon arrives at this figure by calculating its medical needs at home and abroad. At present, the

result is a ratio of 3.7 doctors per 1,000 troops. To physicians in private practice, this ratio looks high; yet during World War II, the ratio was 6 doctors per 1,000 troops. The 13,500 figure, says the Pentagon, can't be reduced.

But on this it will probably get a fight. Many M.D.'s now in uniform say they sit around in training centers with little or nothing to do. Some say they're serving as "clerks"; others complain that they treat only soldiers' "wives and kids."

Opponents of the new bill can be expected to bring such matters to the attention of a waste-conscious Congress. They may argue, too, that the whole concept of a doctor draft is unconstitutional.

Class Legislation

The Pentagon's medical planners, headed by Dr. Melvin A. Casberg, are remarkably sympathetic to such objections. They concede that the doctor draft is class legislation. They acknowledge that here and there the military may not be making the best use of its medical personnel.

But Casberg and his team of planners apparently see it this way: While their proposals may fall short of pleasing the nation's doctors, they've done everything possible to make a limited resource stretch to cover America's needs. They're open to suggestion; but the problem's a real one, and it can't be solved without stepping on *somebody's* toes. END

Doctor Draft Blows Harder

WHAT DO YOU MEAN, YOU'RE
NOT FIT FOR SERVICE, DOCTOR?
YOUR HEART'S STILL
BEATING, ISN'T IT?



© MEDICAL ECONOMICS

There's No Ballyhoo Like Chiropractic Ballyhoo

With every promotional gimmick in the catalogue of huckstering—from testimonials to lawsuits to lobbying—the subluxation specialists are making a grandstand play for public favor

By Morris Weintrob, M.D.

- Nearly all our states have laws sanctioning the practice of chiropractic. This proves nothing about the value of chiropractic; but it does prove something about chiropractors' promotional methods: They really work.

In doleful tribute, a state medical journal commented recently that "some 400 chiropractors who join hands can push around 2,400 un-united physicians, more or less as they choose, in our state's General Assembly."

How do they do it? Are there any bad aspects of their promotion that the physician can counteract? Any good features that offer him a cue? To answer those questions, let's dissect some of the chiropractors' techniques of exploitation.

Chiropractic leaders manipulate words more skillfully than vertebrae. For example, they win support year after year by claiming unfair competition at the hands of the "medical trust" and the "doctors' lobby." They also call themselves victims of "discrimination"—a sure-fire sympathy-arouser.

[MORE→]

A NICE FEELING for artistic anatomy features this chiropractic ballyhoo's appealing portrayal of a pair of pretty 'miracle cure' patients

If This Paper Does Not Convince You Ask for Our 48-Page PROOF Paper

Send your local Chiropractor
or Doctor for additional
information and facts.

MORE

PROOF

Spokes Chiropractic Sanitarium and Hospital

1900 15th Avenue
of America, D.C. 20009

Spokes Office
1000 N. 15th Street
Phoenix, Arizona 85004

PARALYSIS VICTIMS RECOVER

Miss Oklahoma Gained

Her Paralyzed Body

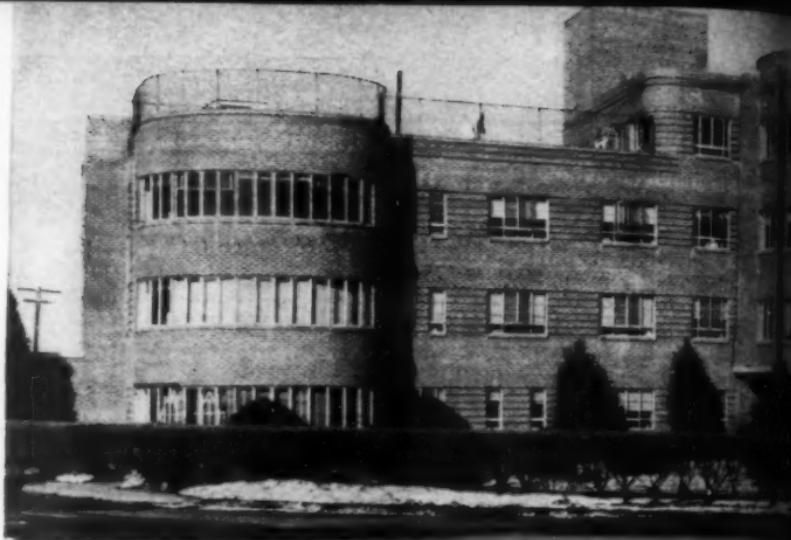
With Spokes

These pictures of Priscilla Greenbaum (left) and Debbie Davis (right) demonstrate how complete and lasting recovery of Spokes hospital from the disease progressive paralysis. Miss Greenbaum had destroyed her career as a dancer because of progressive paralysis. She was cured and now is a successful actress. Debbie Davis was paralyzed from the neck down because of a spinal condition. She has recovered to her vocation as a medical executive. See the "Priscilla" story, page 2; "Debbie" story, page 11.



From Paralyzed Patients See Joy With Spokes

Debbie Davis Demonstrating Her Arm and Leg Strength and Physical Coordination



NOTHING SECRET about the wonderful cures at Spears Chiropractic Sanatorium. The

"Incurable" Buerger's
Disease Mastered
By Chiropractic

Kansas Lady Elated
Over Relief from
Cancer and Arthritis

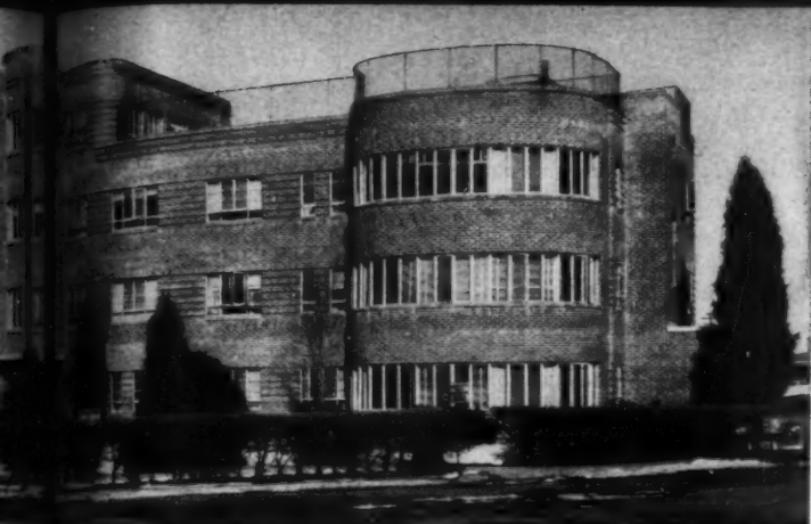
Victim of Tuberculosis
Cured In Spears Clinic

Adjustments Relieved
His Epilepsy; Junior
Now Ambitious to Be
a Chiropractor

With clear-eyed honesty, they admit that "some" of their schools are "not accredited." This lends an odor of sanctity to *other* chiropractic schools. (Few laymen realize that much of the "accreditation" is conferred by chiropractic organizations on themselves.) In the same vein, the chiropractic brass insists that it wants to protect only "qualified" chiropractors—a contradiction in terms not apparent to the uninitiated.

It's true, of course, that a person can learn chiropractic by going to school. So the Veterans Administration considers itself obliged to let eligible veterans go to chiropractic schools under the G.I. Bill of Rights.

This, the spine-men say, is clear evidence of "Government approval"



...ever. They're headlined (below) in Spears' own lively throwaway newspaper

of chiropractic. To quote from one piece of their literature: "The Federal Government, recognizing the value of this science, pays the tuition of veterans at approved chiropractic colleges."

A triumphant bit of verbal magic is a statement in the brochure of the New York Institute of Chiropractic. "Our students," it says, "have access to one of the largest libraries in the world."

They do. It's the New York Public Library, a block away.

Such half-truths are the fruit on which this cult feeds and grows. Witness some other examples:

"Since chiropractic is oriented to the spine, its practitioners define it as a science based on neurology."

"A certain chiropractic clinic re-

Boy Is Saved After Grazing Death with Ruptured Appendix

Declared 'Hopeless' Epileptic Cured At Spears Hospital

VETS' ORGANIZATIONS ASK FOR CHIROPRACTIC

Fame of Dr. Spears' Work Spreads Around World

CHIROPRACTIC BALLYHOO

fers to itself as a "Public Health Service"—naturally inviting a mental association with the U.S.P.H.S.

¶ There's a chiropractic organization called the National Council on Public Health and Research.

Laymen Support It

Testimonials are the backbone, so to speak, of chiropractic promotion. Converts are easily persuaded to allow the use of their names, photographs, and life histories.

While such people may be solicited into saying wonderful things about chiropractic, they're generally not bribed; most of their testimonials are given in good faith. What they often don't know is that chiropractic organizations regularly sell the texts of many testimonials, complete with names, addresses, and pictures, to local chiropractors.

Many lay converts to chiropractic have been encouraged to form lay organizations to further promote the cause. This is a productive tactic: It gives the movement a homey, grass-roots flavor, it simplifies fund raising, it affords good publicity.

Best of all, it creates a fighting corps of respectable citizens whose own motives can't be questioned. From these lay groups comes the manpower for picketing, mass meetings, and letter-writing campaigns.

We hear, for example, of a Citizens' Chiropractic Legion, an Anti-Medical-Monopoly Party, a Laymen's Chiropractic Association, and a Citizens' Action League. Such organizations voice a dramatic and plausible argument:

"If my child is critically ill, if the doctors have given up hope, if I know that a chiropractor can save him—must I stand helplessly by? Have I not the right, as an American, to use the practitioner of my own choice?"

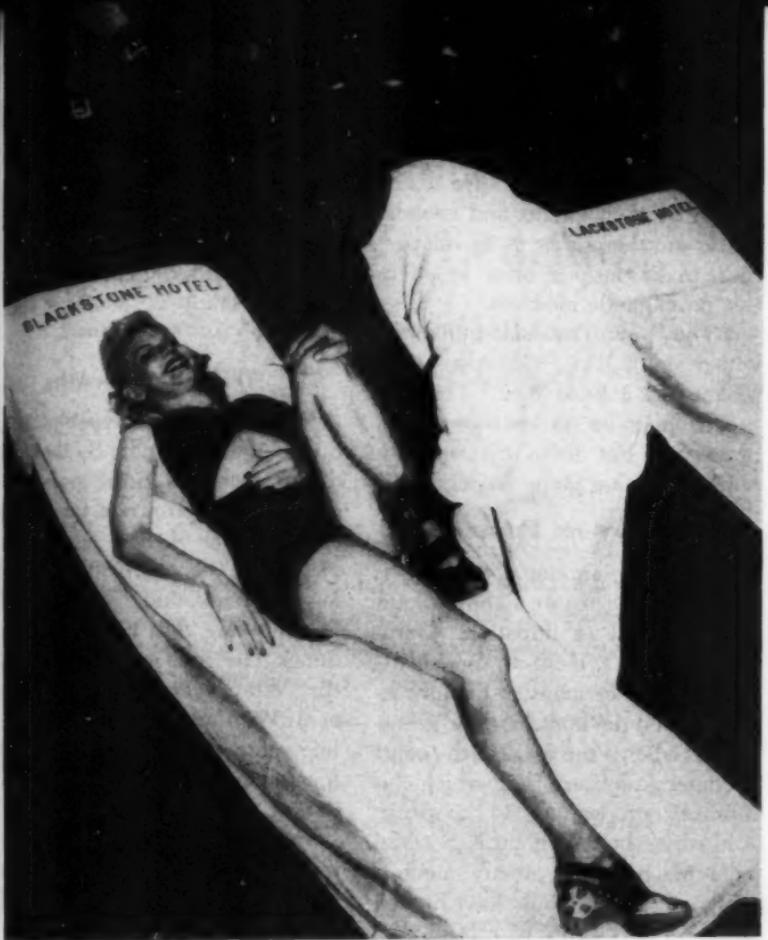
Advertising, in the chiropractic view, is a positive moral duty. A boxed item in a chiropractic newspaper explains why: "We obey the precepts of Christ: to go into the world and preach the gospel."

Among their gospel-spreading devices are these:

¶ They print gummed seals—similar to the familiar TB Christmas

Multiple Sclerosis Conquered and Music Teacher Resumes Her Career

Dr. Spears Discovers Cause of Cerebral Palsy and Mental Deficiency



CHIROPRACTOR AT WORK—in public. With a shapely model cooperating, a group of cultists is treated to what's known as an educational demonstration.

MAN, DOOMED BY CANCER OF SKULL AND BRAIN, LIVED AFTER EPIC STRUGGLE BY SPEARS STAFF

from India Relieved Of 16 Ailments at Spears

CHIROPRACTIC BALLYHOO

seals, but bearing the slogan, "Health Through Chiropractic"—for distribution by their clients and friends. Stuck on thousands of envelopes, these make the post office an effective propaganda medium.

¶ They put up roadside billboards with legends like "Chiropractic Makes Sick People Well." The billboards may be an eyesore to the physician; but they register with telling effect on many passers-by.

Courtroom Forums

Another promotional opening is created whenever a chiropractor gets involved in litigation. Chiropractors don't *want* to be sued—especially since many of them practice beyond the limits of their licenses. But when a suit is tried, the court becomes a platform from which chiropractic propaganda is broadcast. And when the defendant is pictured as a martyr to a greedy medical trust, a trial that should have helped suppress the chiropractor often succeeds in promoting him.

Picket lines and mass protests are the rule at such trials. For example, when a chiropractor was tried last year in Plymouth, Ind., a newspaper reported the following scene outside the courthouse: "Seven cars displayed red, white, and blue banners, and were plastered with signs reading: 'Chiropractic Is Not Medicine'; 'The People Are the Law'; 'We Demand Our Rights.'"

In another case, 500 chiropractic students jammed the Mount Carroll,

Ill., courthouse and, according to the state's attorney, "engaged in a demonstration to intimidate the court and jury." Such devices, whether or not they intimidate anybody, certainly do advertise chiropractic.

Headline Lawsuits

When chiropractors are plaintiffs rather than defendants, they play their court roles in the grand manner. With appropriate fanfare, not long ago, one of them sued Collier's magazine, the American Broadcasting Company, and Walter Winchell for implying that he was a cancer quack (he had merely proclaimed that chiropractic could cure cancer). With a nice sense of the headline value of big numbers, he asked for damages amounting to \$99 million.

In Michigan, another chiropractor brought criminal—not civil—charges against a board of trustees who had refused to let him practice in their hospital. And in Denver, when a physician certified that a patient had died of "criminal neglect," the chiropractor who had attended the patient sued for libel. The jury cleared the M.D.; but the attendant publicity drummed chiropractic ballyhoo into the public ear for weeks.

Radio Huckstering

One of the chiropractors' most potent instruments for disseminating "the gospel" is, naturally, the radio. While medicine's [MORE ON 237]

Externe Deals Said to Put Earning Above Learning

Should an interne or resident sell his spare-time services to some other hospital? It's a hot issue in quite a few cities

By Jack Pickering

- A young interne or resident arranges privately to sell his spare-time services to a hospital other than the one to which he owes first allegiance. Or a senior medical student helps out an overworked staff by doing case histories for pay on his free evenings.

Anything wrong with such extracurricular deals?

They're usually against school and hospital rules, of course; but they've cropped up in many places ever since hospital staff shortages became acute. And doctors in general haven't been notably perturbed at the situation.

Lately, though, unsanctioned externing has appeared in a form—and on a scale—that some leaders of medical education regard as downright sinister. In the Detroit area, for example, the issue has been brought into sharp focus by instances like the following:

A young man approached the administrator of a newly opened hospital. "You're looking for people to run your medical departments twenty-four hours a day," he said. "No need for you to go to a lot of trouble about it. Just make the payment right, and we'll see that you always have enough people when they're needed."

The startling fact: This high-powered entrepreneur was not merely a salesman; he was also an M.D. [MORE→

EXTERNE DEALS

The hospital's answer was a shocked, blunt "no." But the fact that such an offer should be made at all brought into sharp focus a question that, in one form or another, is being scrutinized all over the U.S.

Is the practice of externing being turned into a commercial business, with the part-time dollar beginning to loom so large that young men are forgetting the primary purpose of internship or residency—namely, learning to be good physicians?

Opposing Views

Two attitudes toward externeship are now widely evident:

1. One hospital will insist on a rigid rule that its young men must

not work for any other institution. Their training, it will assert, is a full-time job. There can be no "spare" time to sell elsewhere unless the young man skimps his duties or sacrifices time that's needed to sleep or relax or keep up with his medical reading. Indeed, many a hospital keeps these men on call 24 hours a day.

2. Another hospital in the same city will be perfectly content to let its internes or residents take part-time places in other institutions. They reason that hospitals must have adequate personnel to operate them; and if, as now, a manpower shortage exists, then why not share that manpower?



UNSANCTIONED EXTERNING, says Dr. Gaylord S. Bates (left), "perverts the whole tradition of training." But Norman Henderson, a senior medical student, says many young men need the extra earnings.

Nor is the situation limited to the hospitals.

For example, a busy G.P. in a Detroit suburb solved the problem of night calls by having junior staff members of a near-by hospital take turns on night duty at his office. Result: His patients had round-the-clock medical protection; the doctor got his full quota of sleep; and his part-time assistants picked up some extra money.

Similarly, an undetermined number of hospitals in and about the city have found the externe system a convenient way to fill out their depleted staffs. Men from other institutions can cover admitting and emergency rooms in the absence of the hospitals' regular internes and residents. And students can handle case histories and records, thus freeing staff doctors for other duties.

To some physicians and hospital administrators this seems a sensible arrangement. But not, for example, to Dr. Gaylord S. Bates, associate editor of the Detroit Medical News.

Cause for Concern'

Where, at first glance, one sees a variation on the wholesome theme of a young man working his way through school, "at the second glance one identifies a less admirable character, whose aims are suspect," says Dr. Bates in an editorial. And he comments, dryly: "As it [unquestioned externing] has developed to date, the period of individual competitive bargaining over

wages and working conditions is about finished. Wage rates are standardized at a high level; night, Sunday, and holiday differentials are in force; and complete off-hour coverage is offered if a hospital desires to buy relief for its needs in package form."

His conclusion: "The fundamental cause for concern lies in the attitude . . . that subordinates opportunity for professional growth to immediate financial gain. This attitude perverts the whole tradition of interne and resident training to that of a trade school where one earns while he learns. It runs counter to the ideals of the medical profession . . . It leads to a type of medical practice which the community and the profession alike deplore."

Don't Talk About It

A good many of the young men now engaged in externing are reluctant to discuss it publicly. If their hospital doesn't make an issue of it, they feel, why stir things up?

Some administrators hold precisely the same attitude, and one resident who was willing to defend externship publicly withdrew when his superintendent suggested that it would be better not to risk starting a discussion that might backfire.

The fact remains that the problem is being weighed not only in hospital board rooms but at bullsessions in medical schools all over America, as students, looking toward graduation, try to anticipate

EXTERNE DEALS

decisions they'll soon have to make.

Among the younger men, even as among their elders, the question finds adherents on both sides.

Norman Henderson, a senior at Wayne University College of Medicine, president of the Student A.M.A. there, and a member of the S.A.M.A.'s national executive council, summed up for MEDICAL ECONOMICS the reasoning that the younger men now express:

The Externe's Defense

"Externing isn't the outcome of sheer greed. The student today, as well as the one of twenty years ago, is concerned with the problem of how to become a *good* doctor. But the economic picture has changed.

"We have inflation. We're living in the presence of a conflict that still draws young men to duty. Residents, internes, and students are often men who have lost two to five years because of military service. Many are married; some have children. They can scarcely shrug off the responsibility of supporting their families.

"Presumably, it's quite ethical for them to drive taxicabs, clerk in stores, work nights in a steel mill. Then why is it less honest of them to spend several nights a week in hospital work? Why is it wrong for a man to earn this extra money for his family by doing the kind of work he knows—and loves—best?

"The interne earns a pittance, and the resident not much more. Naturally, they'd prefer to devote all their time to a single post. But they have to accept externing as the most reasonable way to meet a practical problem."

No Solution Foreseen

There are the two sides to the story. As yet there is no indication which side will prevail, or whether the two can be reconciled.

The only sure thing is that, with barely half enough young doctors available for current hospital staff needs—and with new hospitals going up everywhere—the demand for externes isn't likely to diminish. What will happen to the supply remains to be seen.

END

Obstetrical Observation

A woman may have allergies
To nylon, face cream, sun, or peas;
But not to any hour en earth
For birth.

—MARGARET EVELYN SINGLETON

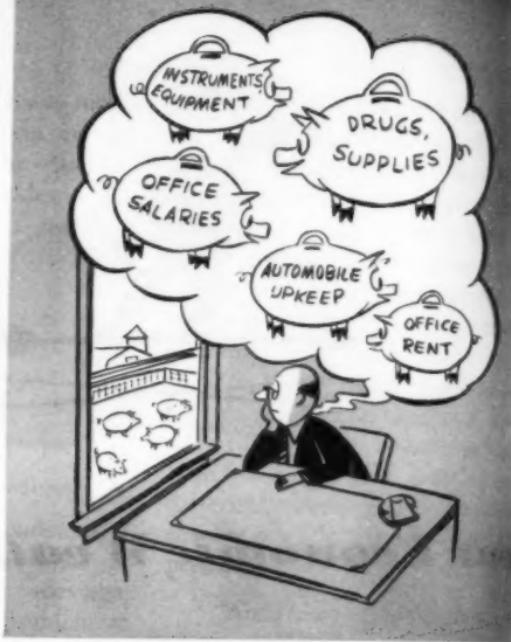


Our Economic Weather Vane

A report on the Seventh MEDICAL ECONOMICS Survey

The facts in the following pages stem from the replies of about 5,000 practicing physicians to a questionnaire sent them by this magazine in April, 1952. These doctors constitute a representative cross-section of the profession; the information they supplied covers many phases of the economics of private medical practice in the U.S. In previous installments of survey data, we discussed such topics as the "average" physician, incomes, and expenses. This month we take up assistants, big-city and small-town practice, and the doctor's contributions to charity. In the final installment next month, we'll cover group practice, salaried practice, and the woman physician. For a detailed account of how the Seventh MEDICAL ECONOMICS Survey was conducted, see page 152.

Your Economic Weather Vane (Cont.)



City Doctor, Country Doctor

• How does medical practice in small towns compare economically with practice in the large metropolitan centers? To help answer that question, the Seventh MEDICAL ECONOMICS Survey responses of doctors in towns of under 5,000 were measured against those of their colleagues in cities of over 1 million.

At first glance, the average small-town physician seems to be considerably better off. He reports a 1951 gross income of \$24,121—a figure 15 per cent

Figures in this article are averages for independent physicians. Most of the dollar amounts given are for 1951; most of the others are for 1952. Independent physicians are considered to be those who derive more than half their net income from fees for service.

higher than the average big-city medical man's gross of \$20,979.

But it doesn't take much probing to discover that gross-income figures can give a misleading impression. For one thing, the average small-town doctor has somewhat higher operating expenses than his metropolitan counterpart. In 1951, his total expenses came to \$10,251, or 44 per cent of his gross. By contrast, the expenses of the big-city physician amounted to only \$7,875, or 39 per cent of his gross.

After expenses are taken into account, in fact, the financial advantage of the country doctor all but disappears. His net income of \$13,870 is only slightly higher than the big-city physician's net of \$13,104.

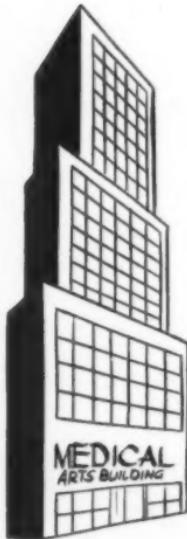
The metropolitan doctor shows up best when in-

Major Expenses

Of Country and City Doctors

	Country	City
Drugs, supplies	\$3,144	\$1,131
Office salaries	2,307	2,091
Automobile upkeep	914	904
Instruments, equipment	702	450
Office rent	570	1,375

Your Economic Weather Vane (City, Country—Cont.)



comes are computed on an hourly basis. His hourly net income of \$4.89 is 15 per cent higher than the small-towner's hourly net of \$4.27.

Why is this so? Because the small-town physician puts in 20 per cent more working hours—working a total of sixty-five hours a week to the big-city man's fifty-four.

In view of his longer hours, it's not surprising that the small-towner sees 38 per cent more patients (thirty-three in a typical day, as against the metropolitan doctor's twenty-four). As a matter of fact, the country practitioner's larger patient load seems to be about the *only* reason he reports a higher income.

Fees, for instance, tend to be somewhat lower in small towns. This is especially true of house-call fees. The median charge of a small-town physician is \$4 for a daytime house call, \$5 for a house call late at night. The big-city doctor's charges are \$5 by day and \$8 by night. (It's also worth noting that the metropolitan doctor makes more house calls: five every twenty-four hours to four for the small-town M.D.)

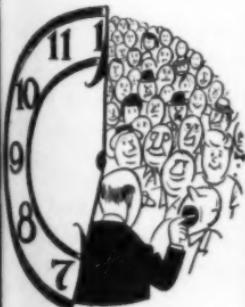
Here are some other facts about practice in small towns and large cities:

¶ The big-city doctor reports an unusually high collection percentage of 90 per cent. The country M.D., on the other hand, gets only 84 per cent of what patients owe him.

¶ Dispensing by physicians is more than twice as prevalent in small towns. Sixty-six per cent of country doctors dispense to some extent; only 30 per cent of those in metropolitan areas do any dispensing.

¶ Largely because of his greater patient load, the small-town physician writes more prescriptions: 2,824 a year, as against 1,848 for the big-city practitioner.

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Data in this article are 1951
figures for independent physi-
cians (those who derive more than
half their net income from fees).

Contributions to Charity

The average M.D.
gives about 7
hours each week
to charity patients

Hours a Week Given to Charity By Specialists and G.P.'s

Dermatology	6.3
Ear, nose, throat	6.9
Eye, ear, nose, throat	5.0
Internal medicine	7.1
Obstetrics/gynecology	7.0
Ophthalmology	6.2
Orthopedics	8.0
Pediatrics	6.2
Psychiatry/neuropsychiatry	7.2
Roentgenology/radiology	7.5
Surgery	7.9
Urology	6.1
All specialties	7.3
General practice	6.6

**Your Economic
Weather Vane**
(Charity—*Cont.*)



Besides giving time to charity, the average physician also gives \$623 annually in cash

**Money Given to Charity
By Physicians With
Various Net Incomes**

Income	Donation
\$ 5,000	\$ 314
10,000	484
15,000	586
20,000	798
25,000	1,083
30,000	1,058



Survey Sidelights

- ¶ The average doctor spends 12 per cent of his working hours doing charity work.
- ¶ His donation of time has increased 15 per cent in four years (1947-51).
- ¶ The dollar value of the time given to charity patients by the average M.D. is more than \$3,000.
- ¶ About seven out of ten practitioners today do some charity work.
- ¶ High-income doctors tend to give more time to charity work than low-income doctors; big-city physicians, more than those in small towns; women doctors, more than men doctors; group physicians, more than those in solo practice.

**Your Economic
Weather Vane**
(Cont.)

Physicians' Aides

Three-quarters of U.S. doctors employ one or more full-time aides

Of the doctors who employ such aides:

65 per cent employ one

23 per cent employ two

12 per cent employ three or more

This article deals with full-time office aides (secretaries, technicians, etc.) employed by independent physicians as of early 1952, and with their average weekly salaries. (Independent physicians are considered to be those in private practice who derive more than half their net income from fees for service.)



Specialists With Aides

(Percentages who employ one or more full-time aides)

Dermatology	73%
Ear, nose, throat	85
Eye, ear, nose, throat	87
Internal medicine	77
Obstetrics/gynecology	86
Ophthalmology	88
Orthopedics	88
Pediatrics	83
Psychiatry/neuropsychiatry	34
Radiogeniology/radiology	87
Surgery	82
Urology	90
General practice	73

**Your Economic
Weather Vane**
(Aides—*Cont.*)

**Aides' Salaries
By Community Size**

Under 5,000	\$41
5,000-49,999	\$41
50,000-499,999	\$41
500,000-999,999	\$41
1,000,000 and over	\$41

Average weekly salary of full-time aides: \$54

**Aides' Salaries
In the Various Regions**

New England	\$43
Middle East	\$46
Southeast	\$51
Southwest	\$48
Central	\$52
Northwest	\$46
Far West	\$47



Your Economic Weather Vane

(Aides—*Cont.*)



Aides' Salaries In Selected Cities

Chicago	\$63
Cleveland	54
Detroit	51
Los Angeles	58
New York	48
Philadelphia	48
St. Louis	54
Washington	51

Survey Sidelights

¶ The number of full-time aides a doctor employs depends, to a large extent, on his patient load. Thus, the majority of doctors who see fewer than ten patients a day employ *no* aides. On the other hand, those who see forty or more generally employ two aides.

¶ Regardless of whether a physician is young or old, or whether he works in a small town or a large city, he employs, more often than not, one full-time assistant. Only among M.D.'s with large practices, netting \$30,000 or more, is employment of two aides the general rule.

¶ The aide who works for a doctor netting under \$5,000 a year draws an average salary of \$37 a week. The aide who works for a man netting over \$30,000 draws \$80.

¶ Quite a few doctors are sold on the advisability of hiring part-time help. Two out of every five, in fact, have such part-time aides.

Your Economic

Weather Vane

(Cont.)

About the

Seventh

MEDICAL ECONOMICS

Survey:

● It was in 1929—a few months before the stock market crashed—that MEDICAL ECONOMICS published the results of its first survey of the economic status of U.S. physicians. More recent surveys, made every few years since then, have examined the doctor's practice through the lean days of the depression, the exhausting days of World War II, and the unsettled days of the post-war period.

The Seventh MEDICAL ECONOMICS Survey is the most comprehensive yet attempted. Like earlier ones, it was planned and prepared for publication by the editorial staff of this magazine, with the technical aid of consultants in research and statistics. The detailed statistical work was done by Columbia University's Bureau of Applied Social Research.

Who participated in the study? Copies of the questionnaire were

sent by direct mail to a cross-section totaling about one-third of the country's active, private physicians. It was also published in the April 1952 issue of the magazine which circulates, of course, to almost all private practitioners. Excluded from the survey group were doctors over 65, internes, residents, and medical men in full-time government service.

About 8,000 questionnaires were returned by the time statistical work was begun. Since this was a considerably larger sample than necessary for stable results, a free hand was used in discarding incomplete or inaccurate returns.

Other questionnaires were eliminated in order to make sure that the sample constituted a valid cross-section of doctors the country over. Actually, the unadjusted sample closely approximated [MORE ON PAGE 227]

ARTMENT OF HEMATOLOGY

clinical Report

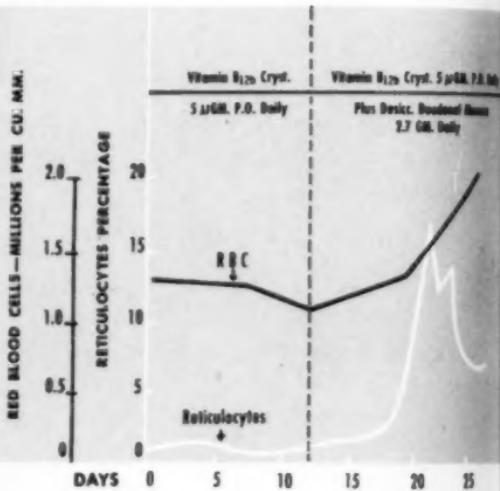
Biopar® tablets given
usually have replaced
injectable vitamin B₁₂
and have produced a full
hematologic response.

Assay 234,235

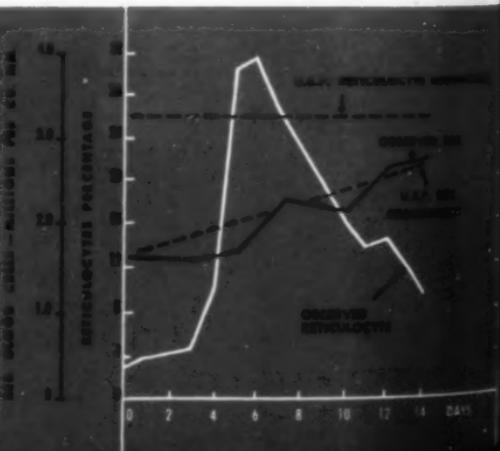


oral **B**₁₂ therapy

Experimental studies by Bethell, et al.,¹ have clearly demonstrated that oral vitamin B₁₂ must be activated by intrinsic factor to produce an optimal hemopoietic response.



Clinical assays of Biopar, containing small quantities of the highly potent intrinsic factor preparation, produced a full reticulocyte and red blood cell response. These assays have been confirmed independently by DeMarsh² and Limarzi.³



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py equivalent to parenteral B₁₂ therapy

Biopar, a new oral vitamin B₁₂ preparation, now provides the same rapid and intense hemopoietic effect as that obtained with parenteral vitamin B₁₂. Clinical investigation^{2,3} has demonstrated that Biopar tablets, when given in a total daily dosage of 30 mcg. of vitamin B₁₂ to patients with untreated pernicious anemia, produced a full reticulocyte and red blood cell response.

Biopar's high therapeutic potency is the result of a completely new intrinsic factor preparation, developed through intensive research in The Armour Laboratories.

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Biopar can be used with complete confidence in conditions previously considered amenable only to injected vitamin B₁₂.

(1) Bethell, F. H., et al.: Ann. Int. Med. 35: 518, 1951; (2) DeMarsh, Q. B.: Personal Communication, 1952; (3) Limarzi, L. R.: Personal Communication, 1952.



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BIOPAR
TABLETS

for oral use

BIOPAR TABLETS...For oral administration

Composition:

Each tablet contains:
Crystalline Vitamin B₁₂ U.S.P. 6 mcg.
Intrinsic Factor 30 mg.

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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

A Medical Man Defends Lay-Sponsored Health Plans

Is group practice with prepayment the best way to provide comprehensive coverage? Here's why one experienced doctor thinks it is

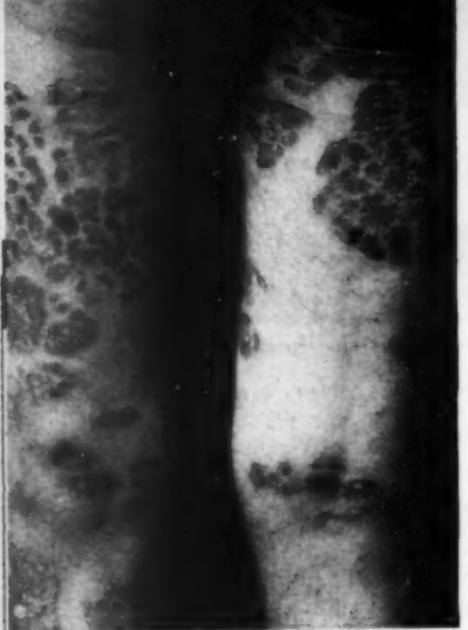
By George Baehr, M.D.

- The independent medical insurance plans differ from the commercial and Blue Shield plans in that most of the independent ones try to provide comprehensive coverage. For this purpose, they find it necessary to operate through prepaid group practice.

With the rising cost of living, people of low and moderate income have a growing need for insurance protection that will permit them to budget *all* the costs of family medical care. In addition, they're becoming increasingly aware of the value of disease prevention and early disease detection. These objectives can be attained through a voluntary prepayment plan only if it provides comprehensive medical care; and this must include all required professional, laboratory, and X-ray services.

Experience in this country has shown that such broad medical care can't be provided by indemnity insurance that remunerates individual physicians on a fee-for-service basis. Coverage under such plans is necessarily limited because the number of professional services that

*This article approximates portions of Dr. Baehr's testimony before ex-President Truman's Commission on the Health Needs of the Nation. The author is president and medical director of the Health Insurance Plan of Greater New York.



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RIASOL FOR PSORIASIS

A MEDICAL MAN DEFENDS LAY-SPONSORED HEALTH PLANS

Individual physicians may choose to under cannot be predicted and because it's impossible, therefore, to forecast costs to the insurance company or to the subscribers.

As a result, the proponents of compulsory health insurance have one good argument on their side—namely, the comprehensive scope of its benefits. Voluntary insurance will never be accepted as the final answer to the problems of medical care until, too, can provide comprehensive coverage to all who want it.

Such comprehensive coverage can be provided for insured families by prepaid medical groups, remunerated on an annual per capita basis. We can't expect commercial companies to do this; they merely pay bills and aren't concerned with the adequacy of medical care. Nor can local medical societies be expected to encourage prepaid groups.

Why not? Because such groups compete with solo practitioners and specialists, who still comprise the bulk of the societies' membership.

At the national level, the A.M.A. has accepted the principle that independent groups of physicians and community leaders should be permitted to experiment with newer patterns of prepaid medical care.

In 1949, the House of Delegates adopted a set of twenty principles to guide state and county medical societies in approving such plans.

But since that time, only one of a hundred or more consumer or city-sponsored plans now in



George Baehr

Claims panel plans are desirable

operation in various parts of the country has been approved by a state medical society. (The conspicuous solitary exception is Group Health, Inc. of Washington, D.C.)

In spite of organized resistance from local physicians, though, prepaid group practice is to be found today in more than a hundred communities in the United States; and it provides comprehensive medical care for about 3 million people.

What Group Plans Do

The independent medical insurance plans are founded on these three basic concepts:

1. The public needs comprehensive medical care at a total annual cost that people of low and moderate income can afford to pay.

2. The ready availability of com-

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prehensive medical services to ambulatory persons is vitally important as a public health measure.

3. Organized medicine, because of its political structure, isn't able to establish the necessary pattern of medical practice to provide such care under voluntary insurance.

For this last reason, most of the independent medical insurance plans have been organized under consumer or community sponsorship, with the aid of groups of physicians. Families that get all their medical services from a prepaid group can completely budget the costs of their medical care. And they have no need to purchase additional care from other physicians.

Free Choice Defined

Therein lies the cause of resistance by the opponents of prepaid group practice. Of course, they say that the subscribers to prepaid group practice don't have free choice of physician. But this criticism isn't valid; for the subscribers exercise free choice when they elect to get their medical care from a prepaid medical group in the first place. If they change their minds after they join, they're at liberty at any time to withdraw from the plan.

In actuality, the members of my profession who try to make prepaid group practice unavailable to the public are *themselves* the real opponents of free choice.

Prepaid group practice plans are defective. For instance, take a look

at the record of the Health Insurance Plan of Greater New York. Today, after five and a half years' operation, the plan provides comprehensive medical care for more than 360,000 insured persons. Within a few months, its enrollment will exceed 400,000.

The services are provided by thirty medical groups, located in various sections of the city. They comprise altogether about 950 physicians and specialists. Each medical group is autonomous and includes an adequate number of family physicians and a complete roster of qualified specialists. The required professional qualifications for membership in a group are determined by an impartial medical control board of representative physicians. The quality of medical care the doctors render is checked by the medical department of H.I.P.

No Extra Charges

It's important to point out that there are no deterring extra charges for any medical services the insured may require in their homes, in physicians' offices, in medical group centers, or in hospitals. All types of medical and surgical services are available to them. These include X-ray diagnosis and therapy, radium and radio-isotope therapy, diagnostic laboratory services, physical therapy, visiting nurse services, and even ambulance transportation without extra charge.

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1. Goodman, L. and Gilman, A.: The Pharmaceutical Basis of Therapeutics, The MacMillan Company, New York 1941, p. 175.

A MEDICAL MAN DEFENDS LAY-SPONSORED HEALTH PLANS

son of age, sex, or pre-existing illness. There are no waiting periods. To protect the plan against the adverse selection to which unguarded individual enrollment might expose it, reliance is placed solely on group enrollment.

'Group Plans Work'

Although H.I.P. is now one of the largest independent plans, its enrollment constitutes only 13 per cent of the total enrollment of the independent plans in this country. The experience of these plans is now voluminous. There's enough of it, at least, to demonstrate that comprehensive medical care through prepaid group practice is professionally feasible and financially practical. There can also be no question of its importance to public health.

For the above reasons, I believe

two steps are probably now in order:

1. Ways should be found to overcome local professional resistance to such plans.

2. Financial assistance should be provided by government, as a public health measure, to encourage the wider extension of prepaid comprehensive medical care by qualified medical groups under appropriate local community sponsorship.

To avoid being misunderstood, let me say that I also favor the continuing extension of medical expense indemnity plans, despite their limited coverage. We must recognize realistically that solo medical practice on a fee-for-service basis will probably endure as the predominant pattern of medical care for a very long time. The transformation of medical practice to a more modern pattern will evolve slowly. END

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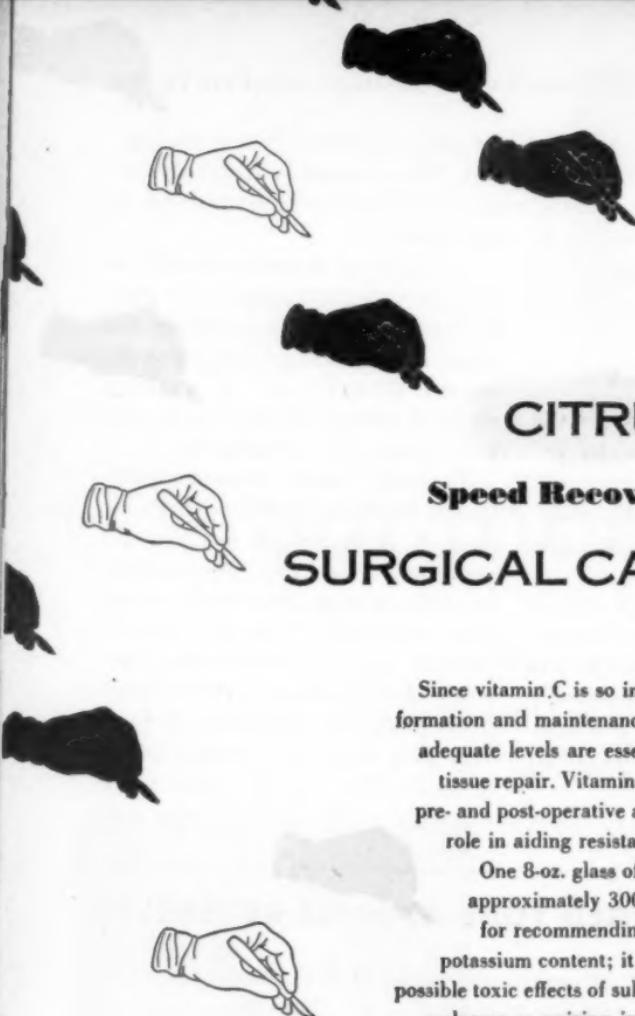
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This G.P. Switched From Busy Practice to Residency

Was his way out of an unsatisfactory situation the best one? He thinks so. What do you think?

By Wallace Croatman

- How does it feel to give up a thriving practice for the humble post of resident? You don't often find a physician who can tell you.

One such man is Harris Taylor—and he'll tell you it feels pretty good. Once an established G.P. in a small Massachusetts town, he's now halfway through a three-year residency at a large New England medical center.*

If a two-year hitch in the Navy hadn't intervened, he would probably have gone directly into a residency from internship. But by the time he was discharged from the service in 1949, he was 29 and married; and he figured that his days in training ought to be about over.

Just at that time he heard of a practice for sale in a rural community of 700 people, some fifty miles from Boston. "So," he recalls, "I borrowed up to my ears and bought the doctor's house, his practice—and his headaches."

On the surface, he made out well. Since there wasn't another doctor for twelve miles around, he didn't have to worry about competition; almost from the beginning, he had more patients than he could comfortably handle.

With most of the early profits from his practice, he

*Except for some necessary disguising of names and other details, the experience described here is an actual one.

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1. *Exper. Med. & Surg.*, 9:90, 1951. 2. *Rev. Gastroenterol.*, 19:660, 1952.

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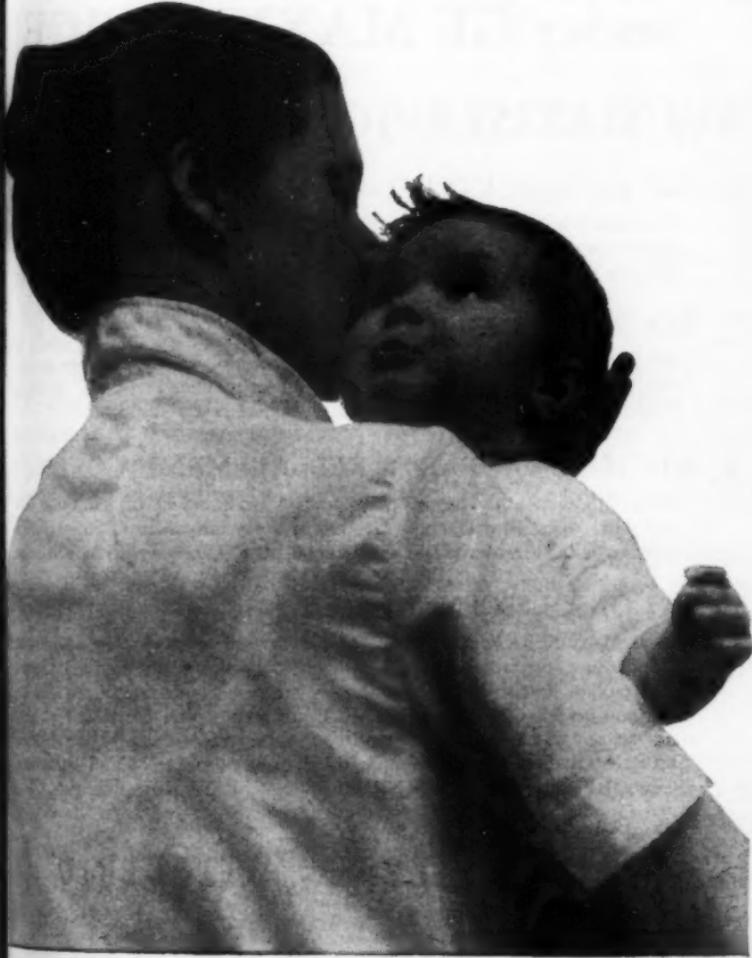
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GENERAL  ELECTRIC

THIS G.P. SWITCHED FROM BUSY PRACTICE TO RESIDENCY

made improvements on his big, old-fashioned home-office and bought needed equipment. By the end of two years, the practice had almost doubled and he had paid for most of the improvements and the equipment.

Yet it was at this point that he uprooted himself and went back into training.

Why?

Partly, he concedes, because the demands of his practice were starting to wear him down. As the town's only doctor, he was on the move, he says, "practically twenty-four hours a day."

Enter Frustration

But what bothered him most was the feeling that, under the circumstances, he couldn't give patients really first-rate care. His equipment was limited; and the nearest hospital was a thirty-mile round trip. As a result, such procedures as X-ray, fluoroscopy, and ECG's were inconvenient to do and sometimes out of the question. Besides, he didn't have time, he says, to treat each case intensively.

Ironically, his patients often seemed skeptical of the few special tests he did order. As he puts it: "If I did something extra and charged for it, the patient was almost sure to complain. The prevailing notion was that I was a 'doctor'—not a specialist—and so had no business charging more than my \$3 office fee."

He felt he was forced, then, to

treat most patients symptomatically. "Let's say a man came in with stomach cramps," he explains. "I had a dozen other patients waiting outside. It was already late and I had some outside calls to make. So I'd give him something to relieve the cramps. But *why* the cramps? There wasn't time to find out."

Isolation, Too

Something else that rankled in Harris Taylor was the sense of being shut off from the rest of the medical world. Since there was no chance of establishing professional contacts locally, he made it a point to take a weekly trip to Boston. He did this even though he knew he couldn't afford the time away from his practice.

In the city, he recalls, "I sat in on lectures, read everything I could get my hands on, visited other doctors and the hospitals. For that one day a week, I was like an alcoholic on a bender."

But there was always the letdown that came when he returned home. And for a couple of days he'd have to work doubly hard to catch up on the backlog of patients.

Not His Dish

Other doctors, of course, get along under such circumstances—and get along well. Or, if they're unhappy in general practice in one location, they try it somewhere else, under more favorable conditions.

Taylor concedes this fact. But he

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S. C. Freed, M. D.—*Newer Concepts in Treating Obesity*, GP, Vol. VII, No. 1, Jan. 1953

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THIS G.P. SWITCHED FROM BUSY PRACTICE TO RESIDENCY

maintains, nevertheless, that "you're either temperamentally suited to that type of practice or you're not. And I guess I'm not cut out for either general practice or a small town."

After two years, therefore, he decided that he'd be doing a disservice to his patients and to himself by staying on.

There were also, he admits, some minor considerations: As a G.P. in a small town, he felt he couldn't have a truly satisfying home life. He says he was the slave of a constantly ringing telephone; his wife had to double as his aide, since adequate local help was hard to find; and there wasn't much stimulating social companionship in the tiny town.

Time for a Change

When he'd pondered all the angles, the answer seemed obvious: "Get out now, before you're saddled with so many responsibilities that you won't be *able* to leave." So he sold his practice to another M.D. and, in September, 1951, he started his three-year residency.

Fortunately, he has managed to make the shift from practice to residency without too much strain. For one thing, he has found that he's still young enough to be a receptive student.

In most ways, he says, he welcomes the change. Nowadays he still puts in long, hard hours; but once his working day is over, he can usually look forward to an uninter-

rupted evening with his family. Most of all, though, he appreciates the feeling of being in the middle of the medical world instead of off by himself.

Problems of Transition

He and his wife, as might be expected, find that their main problem is financial: It's just not possible, he says, for them to make ends meet on his resident's salary—especially since they now have three children.

Chances are, Taylor will be considerably in debt by the time he's ready to specialize. But since there's no way of escaping that prospect, he loses no sleep over it. "After all," he philosophizes, "you can get used to almost anything if you know it's only temporary."

Not that he expects the future to be a bed of roses. He knows that when he's ready to specialize, he'll face many headaches that he never dreamed of in his G.P. days. For one thing, he'll have to build another practice from scratch. And there'll be other problems—centering about hospital privileges, relations with other physicians and the like—that were insignificant in his isolated small-town practice.

G.P. Experience Helps

Still, he feels that he'll profit from some of the things he learned as a G.P. For one thing, he says, the experience helped him develop a "more human attitude" toward pa-

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THIS G.P. SWITCHED FROM BUSY PRACTICE TO RESIDENCY

tients than is generally possible in his present surroundings. It also taught him an awareness of patients' financial problems. As he puts it: "Some of my fellow residents don't seem to realize that you can't go around ordering expensive tests indiscriminately just because the book says they're a good thing."

General practice, he believes, also taught him the basic facts of everyday medical economics—"the stuff they don't teach you in medical school." And, finally, it gave him enough practical knowledge of all fields so that he was able to pick, with conviction, the one specialty that interested him most.

"I knew I wanted to specialize long before I knew what I wanted

to specialize in," he points out. "General practice gave me enough experience in all fields to enable me to weigh the pros and cons of each."

But Never Again

But do these lessons compensate him for the time he spent learning them? Taylor doesn't think so. If he had it to do again, he says, he'd go into a residency as early as possible.

In lieu of that, he regards his decision to give up general practice as one of the best he ever made. Despite his belated start, he thinks he ought to be good for twenty-five years of real productivity as an internist. And he's not at all sure that he could have endured a quarter century of general practice. END



"He doesn't talk English yet; just Be-bop."

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Thiamin Chloride	15	mg.
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Pantothenic Acid (as Calcium Pantothenate)	20	mg.
Nicotinamide	150	mg.
Vitamin B ₁₂ (Activity Equivalent)	10	mcg.
Folic Acid	0.33	mg.
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Distilled Tocopherols, Natural Type	25	mg.
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*A complete, highly potent vitamin combination,
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4 ADVANTAGEOUS FEATURES

- **Lower dosage, higher salicylate levels,** made possible by the presence of PABA.
- **Sodium free,** hence can be given in cardiac disease and with ACTH and cortisone.
- **Better tolerated,** because acetylsalicylic acid is not prone to hydrolyze in the stomach.
- **Guards against vitamin C loss induced by intensive salicylate therapy.**

All pharmacies are supplied.

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Alsical

**especially in the acute
flare-ups of PEPTIC ULCER**

PROLONGED GASTRIC HYPOACIDITY The profound and sustained hypoacidity produced by Alsical is the basis for the desirable clinical performance of this preparation. Through the combined actions of its four antacids, Alsical promptly controls ulcer pain and holds it in abeyance for a prolonged period. Alsical is a non-systemic antacid; it does not lead to alkalosis, diarrhea, constipation or gas liberation.

VAGUS BLOCKING The presence of extract of belladonna in Alsical reduces vagal hyperactivity, aiding in overcoming the discomfort of hypermotility, pylorospasm, and cardioespasm. It also contributes to reducing secretion of gastric HCl.

SEDATION Phenobarbital serves the valuable function of providing mild sedation to allay emotional tension. Thus it enhances the therapeutic value of Alsical, since emotional tension is a frequent factor in the peptic ulcer syndrome.

These actions make Alsical highly effective in the treatment of peptic ulcer, chronic gastritis, and acute gastritis with hyperacidity secondary to dietary indiscretions.

Each teaspoonful (80 gr.) of Alsical Powder provides:

- Phenobarbital . . . 1/4 gr.
- Extract
- Belladonna . . . 1/6 gr.
- Calcium Carbonate . . . 24 gr.
- Magnesium Oxide 10 gr.
- Magnesium Trisilicate . . . 15 gr.
- Aluminum Hydroxide . . . 10 gr.

Available also as Alsical Tablets; four tablets are equivalent to one teaspoonful of the powder.

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A DORSEY PREPARATION

Income Tax Shelter Through Farm Ownership

No 'hobby farms' • Time to incorporate • Capital gains • A deliberate loss • Needn't be full-time • Aim: profit • Tax court decisions • How to operate

By Joseph Berman, LL.B.

• A good many physicians and others in the high income-tax brackets are joining the back-to-the-farm movement. Farm investors can reap some substantial tax advantages—as well as other benefits—by living close to the land.

But to do so, the doctor-farmer must be able to prove that he bought the farm for profit—not merely as a hobby. If he runs his farm simply as a country home, he stands to lose the special tax benefits enjoyed by legitimate farmers.

No 'Hobby Farms'

This doesn't mean his venture must show a profit in any particular year. The main question is whether or not it was entered into as a tax-evasion device.

The shrewd investor generally buys a farm that needs rehabilitation and was previously operated at a loss. In the first few years of operation, the outlay is of course high, the income low.

Usually such a doctor will begin by operating the farm in his own or his wife's name. He can then deduct

*This article approximates one written for *The Mississippi Law Journal* (Vol. XXIII, p. 130). Joseph Berman is a New York City attorney.

pain

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R. J. STRASENBURGH

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Strascogesic acts directly in three ways, maintaining its effect for 3 to 4 hours.

- ... Provides rapid and effective analgesia
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- ... Relaxes tension

Strascogesic is exceptionally well tolerated and of particular value in the treatment of dysmenorrhea, rheumatic and low back pain, muscle and joint pain, headache, colds and gripe. Average adult dose, 1 to 2 tablets every 3 to 4 hours.

...it works!

analgesic

Each Tablet Contains:

Acetyl-p-aminophenol	300 mg.
Salicylamide	200 mg.

anti-depressant

Raphetamine (racemic amphetamine phosphate, monobasic)	2 mg.
--	-------

relaxing

Metropine® (methyl atropine nitrate) 0.5 mg.

Strasenburgh

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"...for the first time in his life he developed a real appetite."

Here is a case history from a Philadelphia Pediatrician. It illustrates the clinical results achieved with 'Trophite' in below-par children:

Patient: Jim B., age 12, height 55 inches, weight 75 pounds. "...had been a very marked feeding problem since birth . . . was always called the 'runt' . . . a psychological problem."

Treatment: "He was started on 'Trophite' and for the first time in his life he developed a real appetite." One teaspoonful of 'Trophite' daily for 2 years.

Results: During first year he gained 13 pounds and grew 3 inches. "His appetite continued to improve . . ."

At the end of 2 years he weighed 108½ pounds and was 63½ inches tall—a total gain in weight of 33½ pounds and increase in height of 8½ inches.

Comment: ". . . no longer the 'runt' in his class . . . a much happier and better adjusted child."

Smith, Kline & French Laboratories, Philadelphia



B₁₂ plus B₁

to increase appetite and growth
in below-par children

One teaspoonful (5 cc.) delivers 25 mcg. of
Vitamin B₁₂ and 10 mg. of Vitamin B₁.

*T.M. Reg. U.S. Pat. Off.

INCOME TAX SHELTER THROUGH FARM OWNERSHIP

Operating costs in full as an offset to personal income from other sources.

Time to Incorporate

Later, as the farm becomes profitable, he incorporates it. The corporation uses the profits to help pay off the mortgage on the property; and the corporation becomes liable for the income tax on the farm. Thus the doctor is relieved of tax liability as an individual.

Money invested in improving a farm is often well spent—especially since in some instances it's not likely to be taxed. This tax benefit occurs because the value of the farm increases considerably with such improvements; and if the physician-owner eventually decides to sell the farm his total profit will probably be taxed at the rate for capital gains.

Capital Gains

On the other hand, if the doctor keeps his farm, it becomes part of his estate when he dies. Inheritance taxes will then be leveled on the estate as a whole; and the farm, if not sold, will escape the gains tax that would otherwise apply to the spread between its original book value and its current market value. In fact, its higher current value may become the cost basis for a new cycle of depreciation. And that may mean real tax savings for the physician's family.

In case of an exchange of farms, there's no capital gains tax at all—

even if the doctor gets a better farm than his original one. And if the farm is sold at a loss, the entire loss can be deducted.

A Deliberate Loss

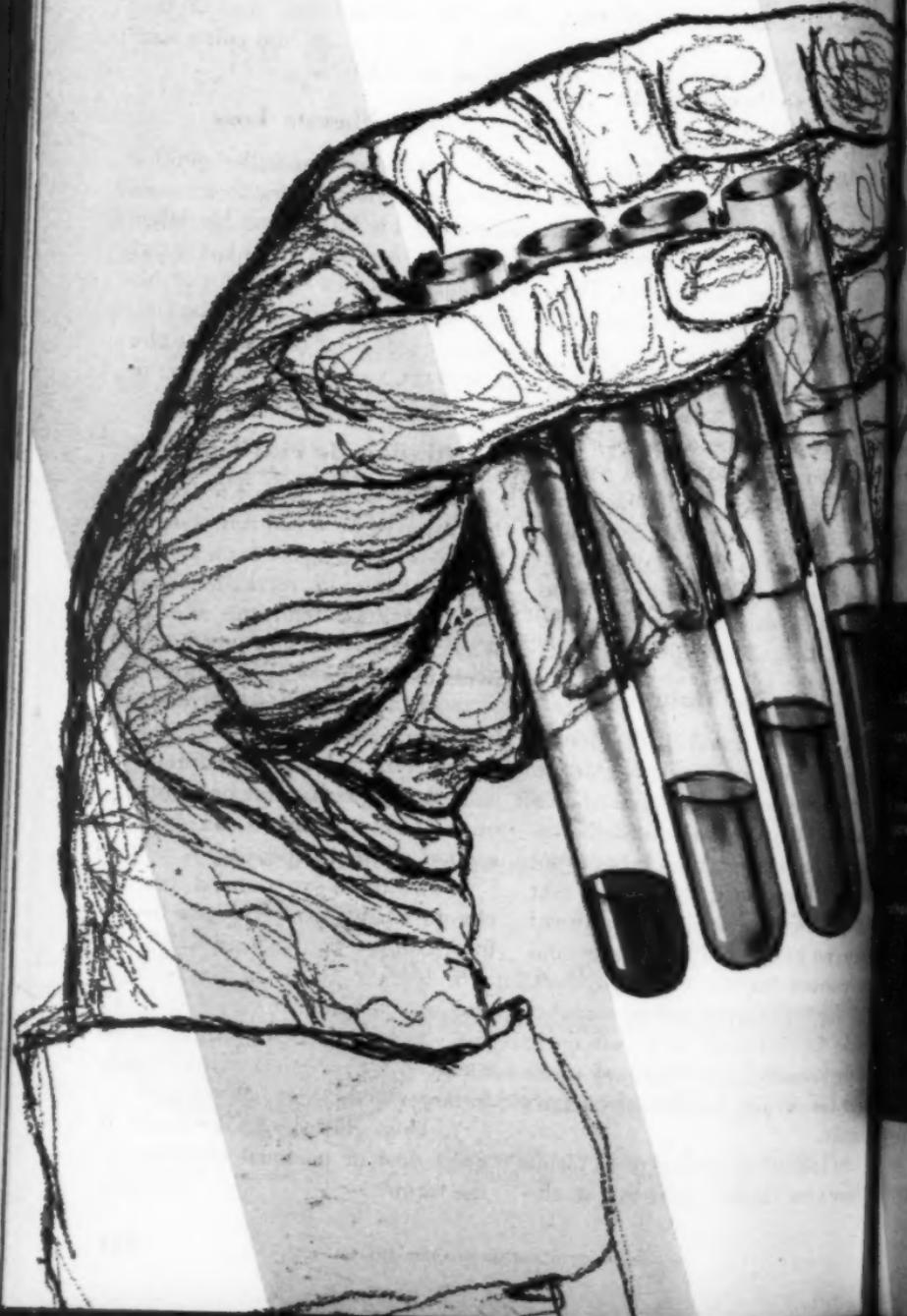
Usually, when a so-called gentleman farmer deducts the losses sustained on his farm from his other income, the Bureau of Internal Revenue becomes suspicious of his true status as a farmer. It won't allow such deductions where the farm is run merely as a diversion or to incur a deliberate tax loss.

Needn't Be Full-Time

The Tax Court doesn't insist that the taxpayer be a full-time farmer. Nor does it frown on a farm just because it has more recreational and social facilities than the average. What it does want are positive answers to the following questions:

1. Are there appreciable receipts from farm sales?
2. Are farm losses decreasing?
3. Are improvements being made on the farm to increase efficient operation and cut expenses?
4. Are there experienced men in charge, and are they given the benefit of consultation with experts?
5. Is there proper accounting and bookkeeping?
6. Are unsuccessful transactions replaced by others that may bring in larger income?
7. Does the physician devote a good deal of personal attention to the farm?

[MORE→]



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Homatropine methylbromide.....2.5 mg. (1/24 gr.)
Phenobarbital.....8 mg. (½ gr.)

AGENT	CLASSIFICATION	EFFECT	FLUSHING EFFICIENCY	COMMENT
	Chologogue	Promotes evacuation of the gallbladder	+	Utilizes only bile of normal viscosity present in the gallbladder
	Choleretic	Stimulates secretion of normal bile by the liver	++	Utilizes increased amounts of bile of normal viscosity
	Hydrocholeretic	Stimulates secretion of fluid bile by the liver	+++	Utilizes copious amounts of free-flowing bile - adequate in absence of spasm of sphincter of Oddi
	Hydrocholeretic, parasympatholytic, sedative	Stimulates secretion of fluid bile by the liver, and relaxes sphincter of Oddi spasm	++++	Utilizes copious amounts of free-flowing bile and relaxes smooth muscle spasm for greater therapeutic efficacy

8. Is his household charged with the market price of farm products used?

9. Does the farm manager share in the profits?

Aim: Profit

A decisive factor in all these cases is the clear intention—not merely the hope—of running the farm profitably. This is usually indicated if large quantities of produce are sold at prevailing market rates and if business principles and practices are followed in running the farm. Tax relief is denied mostly in cases where heavy losses are the rule and realization of profits is problematical.

Tax Court Decisions

In a recent example, the Tax Court ruled that a taxpayer must at least *plan* for a future profit from his farm. In the case under consideration, said the court, the taxpayer had only hoped to run the farm profitably; he had shown no real determination to do so.

The proprietor of the farm apparently had substantial outside sources of income. He used the thirty-room farmhouse as his residence, and he commuted between it and his office.

The farm, when he bought it in 1935, had five cows and a bull. By 1940, the herd had increased to twenty-nine; by 1947, to forty-one. He had been advised that the farm couldn't be run profitably with less than 150 head of cattle; but he

hadn't availed himself of the advice.

Said the court: "Early losses were expected, but continuous operating at a loss leads to suspicion that the operation of the farm in this case lacked the profit motive."

In another case, the court disallowed losses when it decided that the owner was keeping his farm on as a country home, with no thought of profit.

The proprietor was a doctor who had intended to retire from practice and had bought the farm to retire to. But he never carried out his plan. He continued to practice; his family spent their summers on the farm, and he vacationed on it. His only active interest in farming took the form of occasional instructions to his hired farmer.

For thirteen consecutive years there were losses, or else no farming was done at all. But in the tax year involved, the physician had bought seed, stock, and farm equipment, and he had employed a sharecropper.

In view of these facts, the court found that only an "incorrigible optimist" could have expected any immediate profits from the farm.

How to Operate

In another case, the court took an opposite stand: It allowed deduction of losses where a doctor had lost money in operating his farm for fourteen consecutive years. Here's why:

The doctor-farmer had increased

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To Stimulate Appetite

Often all that is needed is the stimulating effect of one of these two good tonics. Next time you face the appetite problem—in the convalescent, or in almost any patient—try either of these preparations. They work.

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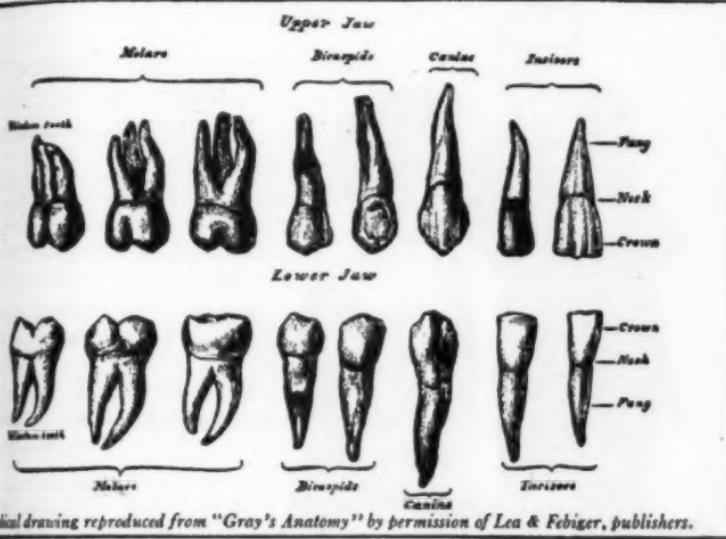
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to get a patient to give up coffee . . .



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SUPPLIED: 2 shades each strength blonde and brunette, bottles 4 fl. oz.

OINTMENT — for daytime masking of lesions. Washable penetrates rapidly.

SUPPLIED: 2 shades, blonde and brunette, tubes $1\frac{1}{2}$ oz.

SOAP with Salicylic Acid
SUPPLIED: cake 4 oz.

for associated seborrhea of scalp

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Plain, for oily hair...

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INCOME TAX SHELTER THROUGH FARM OWNERSHIP

his pastureage and cultivated land from seventy-five to ninety-five acres. He had employed an experienced farmer to operate it under his supervision. He had improved the land by fertilization, reclamation, and soil conservation.

He had also experimented with various types of farming in search of profits. He had worked weekends on the farm, repairing buildings and equipment, spraying the orchard, and feeding the poultry.

Furthermore, he had consulted his farmer regularly on farm problems, and he had spent money re-

pairing buildings and buying equipment for *useful* purposes rather than for the beautification of the property. In addition, he had kept a separate accounting and bookkeeping account for the farm, and he had confined his social activities to his home. Finally, he had included in his farm income the products consumed by his family, and had charged regular prices for them.

Let the doctor who buys a farm model himself on the last man. Let him do so, at any rate, if he expects the farm to give him some shelter from taxes.

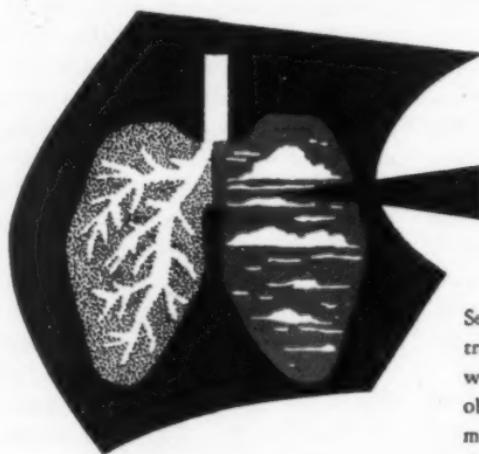
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Advantages

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Subcutaneously or intramuscularly with a minimum of discomfort.

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One or two doses per week in many instances.

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Combines the two-fold advantage of sustained action over prolonged periods of time with the quick response of lyophilized ACTHAR.

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Severe bronchial asthma can now be treated in the home and in the office with a degree of success similar to that obtained with hospital care. Improvement is prompt and dramatic. Neither the patient's age nor the chronicity of the asthmatic condition detracts from the efficacy of ACTHAR treatment, which has stood the most severe of all tests of usefulness—the requirements of the general practitioner. The use of the disposable cartridge syringe—an immediately available form of HP^{*} ACTHAR Gel—can be a life-saving measure in the medical emergency which suddenly arises in the course of long-standing "intractable" asthma. HP^{*} ACTHAR Gel has demonstrated its superiority over customary measures in many instances of bronchial asthma, and has brought about gratifying remissions lasting as long as 18 months.

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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

Don't Sell Yourself Short

***Do you ever make light of a patient's complaint?
It may cause him to undervalue your services,
thus bringing on unwarranted fee disputes***

By William MacDonald, M.D.

● "You must think I'm John D. Rockefeller," the patient wrote across the bottom of the bill. "I don't see why I should pay \$15 just for having a small cut treated."

Oddly enough, my colleague who got this protest didn't charge too-high fees. But in this case he'd made them *seem* so by an impulsive effort to calm the patient's fears.

"It's just a small cut," he had said, while suturing the man's finger. So the patient had reasoned that a small fee was in order.

That's why the \$15 bill had struck him as being way out of line. He paid only \$5 of it. And soon afterward, he switched to another doctor.

Moral: Don't try to reassure a patient by unduly minimizing his trouble—and, consequently, your services.

Take, for instance, the case of the surgeon who tried to save a frightened old lady some worry. "An appendectomy these days is a relatively simple operation," he told the prospective patient.

"Then why," asked her son who'd accompanied her, "should the fee be \$200?" He eventually took his mother elsewhere.

There are several other ways to stir up such trouble. You may, for instance, be selling your service short:

1. *If you fail to explain your diagnosis.* Most patients

Mephosal

controls both MUSCLE SPASM
and MUSCLE PAIN in the
ACUTE LOW BACK

arthritis, bursitis, sacroiliac strain and other rheumatic conditions

MEPHOSAL provides not alone the safe, modern relaxant action of mephenesin for control of muscle spasm, but also the specific pain relieving effects of salicylate...to break more completely the cycle of pain—spasm—more pain in rheumatic disorders. Mephosal increases ease and range of motion, minimizes crippling postural deformities, and allays concomitant gastro-intestinal symptoms.

DOSAGE: one teaspoonful elixir or 2 or 3 tablets every 3 or 4 hours; preferably given p.c.

HOW SUPPLIED: MEPHOSAL ELIXIR in bottles of 8 oz. and 1 pt.
MEPHOSAL TABLETS in bottles of 50, 100 & 500

composition of MEPHOSAL

Mephenesin
Sodium Salicylate
Homatropine Methylbromide

Tablets	Elixir
125 mg.	400 mg.
125 mg.	400 mg.
1.25 mg.	2.5 mg.
in each tablet	in each teaspoonful (4 cc.)

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Therapeutic Preparations for the Medical Profession

DON'T SELL YOURSELF SHORT

don't realize how much knowledge and skill lie behind their doctor's diagnosis of even a minor ailment. As they may not appreciate what they're getting for their money—unless he manages to give them some idea.

The dermatologist who merely reported "seborrhea" after a quick skin check didn't seem to be doing enough to earn his fee. At least that's how the patient saw it. So he saw another doctor, who came up with the same diagnosis. But this time, the patient felt, deserved every cent of his bill because he took time to explain the cause of the trouble and the reason for the recommended treatment.

Unwarranted Optimism

1. If you fail to indicate possible complications. Suppose, in an effort to calm the patient's family, you say "There's no cause for worry"—even though the prognosis is not quite so favorable. This can boomerang, as many an M.D. has discovered.

In fact, the doctor then stands to gain no matter how things turn out. If suspected complications fail to materialize, he gets credit only for treating, say, a common cold; and the patient may resent the expense of "unnecessary" visits he's made.

On the other hand, if serious trouble develops, the physician may be blamed for not having anticipated it. A family doctor I know got an undeserved reputation for incompetence in just this way:

Not wanting to alarm people, he had told several families not to worry about their children's fever—even though he recognized the possibility of polio. Later, when the disease actually manifested itself in some of the youngsters, he was criticized for having failed to spot it.

Specialist's Problem

3. If you're casual about difficult procedures. Many an M.D. gets so adept at certain specialized procedures that he tends to view them as routine. But if he conveys this attitude to the patient—well, who wants to pay more than a routine fee for what appears to be routine service?

Obviously, this isn't to suggest that you exaggerate every ingrown toenail and diaper rash into a major crisis. Your proper aim should be to give the patient an accurate, all-sided understanding of his condition—plus the conviction that he's getting the best care medicine can provide.

[MORE→]



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... helps normalize liver function, increase phospholipid turnover, reduce fatty deposits, and stimulate regeneration of new liver cells...

... helps reduce elevated cholesterol levels and chylomicron ratios towards the normal, and aids in achieving normal fat metabolism.

the suggested daily therapeutic dose of 9 capsules or 3 tablespoonsfuls of Méthischol provides

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Vitamin B_{12}

Liver Concentrate and Desiccated Liver** 0.75

* Present in syrup as 1 Gm. Choline Chloride

** Present in syrup as 1 Gm. Liver Concentrate

now — higher B_{12} potency



now! **methischol injectable**

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2 cc. ampule for intramuscular use,
10 cc. ampule for intravenous
use under proper dilution.

for use when oral therapy
is impractical or impossible.



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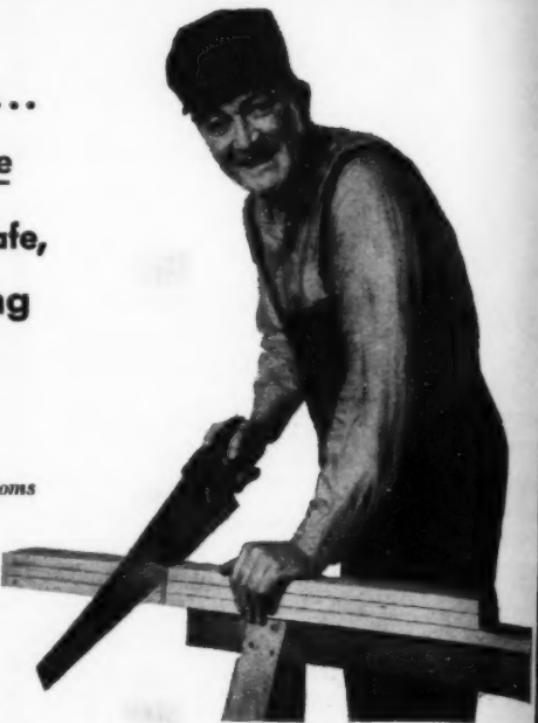
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Wherever
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RAHWAY, NEW JERSEY

One physician I know, to keep from belittling his services, uses the following set of reminders. You'll seldom sell yourself short if you abide by them:

| Tell the patient as much about the condition in general—and his case in particular—as your time and his intelligence allow.

| Indicate as many of the factors behind your advice and prescription as you can.

| Be honest with patients—without being blunt or overdramatic.

| Let surgical patients know that there's always *some* danger, but that most precautions are being taken.

| Try to answer all questions adequately—even the silly ones.

| Banish from your conversation such phrases as: "It's nothing"; "Don't worry about it"; and "Nature does 99 per cent of the work—I only help her along."

END

Advertisement

From where I sit by Joe Marsh



Wrong "Train" of Thought

Most of us knew the streamliner stopped about four miles from town Thursday—but we didn't know *why* . . .

Seems the train was hurrying along, then came the screeching of brakes — some fellow had pulled the Emergency Stop cord.

When the conductor asked him why he did it, he quickly replied, "The train was going much too fast—I wanted to get you to slow down."

From where I sit, that streamliner has been going at that speed for the past seven years with a perfect safety record and the passengers have always been pleased.

Now—along comes a fellow who wants the train to go at his speed. Some people are like that. They would tell a neighbor how to practice his profession . . . others would begrudge his right to a glass of beer—even though they wouldn't dream of flashing a "Stop" sign on preferences for, say, milk or tea. Respecting the rights of others is a way we can all keep "on the right track."

Joe Marsh

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GOOD, basic foods though they be, meat and potatoes hardly can supply Mr. Moss with a balanced diet. How he could use a new dietary and DAYALETS, the fishless, burpless multivitamins. No allergies due to fish oils —the vitamin A is synthetic. In bottles of 50, 100 and 250.

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Each DAYALET tablet represents:

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Riboflavin.....	5 mg.
Nicotinamide.....	25 mg.
Pyridoxine Hydrochloride.....	1.5 mg.
Vitamin B ₁₂	1 mcg.
Pantothenic Acid.....	5 mg.
Ascorbic Acid.....	100 mg.

If You Need to Borrow Money

CONTINUED FROM 119]

Chattel mortgages on home or office furnishings are a different matter. Because such property is not easily handled or disposed of in case of default, loans based on it may be extremely costly. As a rule, banks are not willing to deal in such loans, and only small loan companies will do so.

Generally, it's best not to offer real property as security for a small short-term loan. The fixed minimum expenses connected with a mortgage—for title search, drawing up a bond, and legal fees—are likely to run to \$200 or \$250, making the loan too costly.

But if a long-term loan for building is what you're after, a mortgage may be the most convenient, if not the cheapest, answer.

The important point to remember is that with adequate security you can borrow more money at less cost—always presuming that the amount doesn't exceed your ability to repay. Why this hedge? Because, while collateral insures the lender against loss, forced collections through liquidation create problems which lenders prefer to avoid.

Final Reckoning

What will your loan cost you? At one extreme, you may pay at

the rate of 3 per cent a year for a fairly large short-term bank loan—say, \$2,500 for ninety days—if you are considered an A-1 credit risk. At the other extreme, you might pay as much as 42 per cent a year to a small loan company. Chances are, you'll find yourself a lot nearer the lower-cost end of the scale than the higher.

If you need a lot of cash for a limited period—possibly to take advantage of an inviting investment opportunity—a short-term loan (also called a "term" or "commercial" loan) may be indicated. Generally, such a loan will be available only to a doctor who's well-established, and it will be repayable in ninety days. The "prime" rate for blue-ribbon borrowers is 3 per cent a year; but 5 to 6 per cent is more common.

Short-term loans are frequently made with the understanding that they may be renewed in smaller amounts. Thus, it may be possible for you to extend a ninety-day \$5,000 loan over a period of a year, with four pay-off days, and still get the best interest rate.

If the short-term loan isn't your dish, then the commercial bank's personal loan department probably offers the next best bargain. "Discount" interest rates on personal loans run as a rule from about 3 to 6 per cent. Rates are generally lower in the big cities, where volume is large and competition keen. They're generally higher west of the Mississippi.

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*Gordon, H. H.: Feeding of Premature Infants, Am. J. Dis. Child. June 1947.



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IF YOU NEED TO BORROW MONEY

However—as your bank will tell you frankly—the “true” or “effective” interest rate on personal loans is nearly double the “discount” rate. The latter term means that the interest is “discounted,” or deducted, in advance; thus, you don’t get the full face value of your loan. And because you must pay back the loan on the installment plan, reducing it periodically, you don’t have the use of all the money for the full term.

How It Works Out

For example, a large New York City bank sets a top discount rate of 3.83 per cent on personal loans. But because of the discount feature, the borrower actually gets only \$96.17 for each \$100 he must repay. And since the debt is reduced in twelve equal monthly payments, he has the use of only about half the total sum for the entire year. So the *true* interest rate is more than 7 per cent.

The same loan discounted at 6 per cent—a rate favored in many smaller localities—would show a true interest rate of nearly 12 per cent.

These discount rates are high partly because life insurance is added, at no extra cost, for the amount of the loan. This means that if the borrower dies before he has paid up, his estate doesn’t have to complete the payments.

But if your personal loan is secured by your automobile, stocks, bonds, or savings-bank passbook, the discount rate at the aforemen-

tioned New York bank is only .33 per cent—since no life insurance is required. The true interest would then add up to a little over 1 per cent.

For an equivalent personal loan at an industrial bank, you’d have to pay an even higher true rate of interest. The reason: special service fees, which may run from 1.25 to 1.50 per cent extra.

Some Comparisons

Not all personal loans are made on a discount basis, though. There is also the “add-on” loan, where the interest is *added* to the sum borrowed and then repaid along with the principal. An “add-on” loan costs less, actually, than a discount loan. For instance, if interest of 10 per cent on \$100 is *discounted*, the borrower gets only \$90 and repays \$100; thus, he borrows \$90 at a cost of \$10. But if the interest is *added*, so that he gets the full \$100 and repays \$110, he has the use of more money at the same price.

The fact that an add-on loan is a better deal shows up plainly in the true interest you pay. If repayment is made in twelve equal installments, true interest on a 10 per cent discount loan is close to 20 per cent. On a 10 per cent add-on loan, true interest is about 18 per cent.

Naturally, not many banks charge as much as 10 per cent, added or discounted, for personal loans. But some other lenders charge considerably more. Borrowing \$100 from a

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PEDIATRICS

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

BULLETIN

Security in DISCIPLINE

THE PHYSICIAN working with children frequently is forced to make decisions in the controversial field of child psychology. He has been urged to swing from the old rigid training and feeding programs to one where free expression of impulses is allowed the child, who, as an infant, is expected to select the time and amount of his feeding, and later to decide his hourly program for amusement and education.

• The Physician may believe that many a young child derives a great



OVER 50 VARIETIES—Strained Foods, Junior Foods, Pre-Cooked Cereals

*Journal of the American Medical Association,
Vol. 149, p. 170, May 10, 1952



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This Bulletin Accepted By The Council
On Foods And Nutrition Of The American
Medical Association

feeling of security from a real and discipline against which he sometimes protests. If we indulge in philosophical speculation about in fields of emotional development, we can understand that many children cannot quickly accept the of intrauterine containment for independent life. It seems wrong to force some small children prematurely to make all decisions when and what they shall eat, and how they shall play, go to bed by themselves, confusion, and lack of sleep. Many normal children still develop into strong-minded and intelligent individuals with normal initiative under a system of sympathetic discipline and control which they look back upon with satisfaction and admiration.

NOTE: These bulletins are designed to disseminate modern pediatrics known to the general medical profession and appear monthly in *Medical Economics*.

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IF YOU NEED TO BORROW MONEY

ical New York small loan company at 17 per cent would cost you interest at the rate of about 34 per cent. That's not far under the per cent a month a pawnshop would charge if you were reduced to hocking your watch.

To put the comparison another way: In 1951, U.S. borrowers received around \$800 million from small loan companies. For this they paid about \$136 million in interest. Development personal loan departments kept the same period for about \$120 million in interest. In other words, the small-loan customers paid money at a rate nearly three times that paid by the bank customers.

If You're a Veteran

If you're a veteran, some of the most liberal loan arrangements are available to you under the G.I. Bill Rights. To get a G.I. loan, you apply at a bank, just as you would for a personal loan; but you pay only 4 per cent interest *on the outstanding balance*. Since this 4 per cent is true interest, the G.I. loan is obviously less costly than a personal amount loan.

An official of one bank points out that many G.I. loans are made to young doctors just starting in practice. At this institution, such loans usually run from \$4,000 to \$6,000; and they're repayable in installments within three to five years.

Veterans of World War II have until July 25, 1957, to apply for

G.I. loans. While every such loan is guaranteed by Uncle Sam, it must still be secured by the same type of collateral that would be acceptable for any other loan.

For Office Repairs

Another Government-guaranteed loan—and one that's not restricted to veterans—is a good bet if you need money to repair or remodel your home or office. This is the F.H.A. property-improvement loan. Such loans are available to you only if you have an equity in the property to be improved, or else a lease with a fixed term expiring not less than six months after maturity of the loan.

Generally, F.H.A. loans up to \$2,500 require no co-signers. They run for three years; and they carry an annual discount rate of 4 or 5 per cent on the original amount borrowed. They're amortized by a schedule of monthly payments.

But you're eligible for an F.H.A. loan only if you plan to make permanent changes or installations in your building. For example, you can't get an F.H.A. loan in order to buy a removable carpet; but you probably can get one to install a tile floor.

Says an officer of the American Bankers Association: "This type of loan has proved extremely helpful to thousands of doctors throughout the country."

Last, but by no means least, there's the question of borrowing to

IF YOU NEED TO BORROW MONEY

buy some article of equipment or other so-called durable commodity. If what you want is an automobile, an X-ray unit, or a washing machine, you'll be wise to do comparison shopping both at the bank and at the dealer's place of business. You'll find that terms of installment buying, where time payments are arranged directly with the concern that sells the article, may vary even more widely than terms for cash loans.

Often the finance charges of retailers are considerably higher than the prevailing local bank rates. Four out of five car buyers, for example, unquestioningly use the credit facilities provided by dealers. Yet a trip to a bank's personal loan department may easily save you fifty to a hundred dollars on such a transaction.

Bargain Installments

The exception worth remembering is that a few suppliers charge less than bank rates. They use their credit standing to make your purchase on the installment plan more economical. Some of the companies that sell medical and surgical equipment are in this category; they offer the physician genuine bargains in credit.

The head of one concern that sells X-ray equipment at very moderate installment rates has pointed out that the physician, after all, is an excellent credit risk. For this reason, he says, doctors should have little

trouble securing credit on favorable terms.

"The doctor's diploma," he adds, "is the only credit reference we want. Long experience has shown that our confidence in medical men is justified. Our losses through going to them on credit have been negligible."

Advice From a Banker

There are other angles to the consumer loan business that the doctor—a layman in this field—may need to know. But if you shop for your loan primarily on a cost basis, and if you deal only with reputable lenders, you won't go far astray. Probably the best place to start is with the loan officer of your bank. He'll explain the best deal he can offer, and you can use it as a yardstick from there on.

The American Bankers Association offers these words of general advice to the doctor shopping for a loan:

"Get acquainted with the credit managers and loan officers of the banks and other lending institutions in your community. Find out how each one operates and how much you'll pay for its services. What will its policy be if the going gets rough? Will it appreciate your position and try to cooperate? Or will it get hard-boiled and invoke policies that will be difficult to live with?"

"These are questions you can, and should, have the answers to before you borrow."

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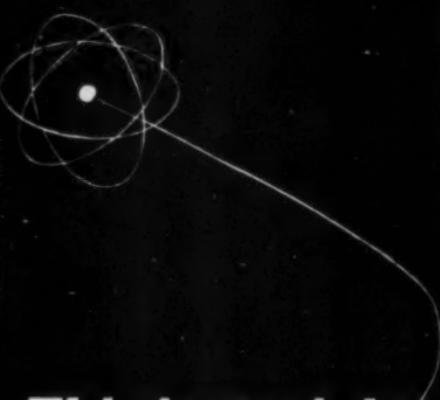
¹Hermann, J. P., and
Smith, R. E., Jr.
Lancet 21:327
(July), 1960.

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1. Hufford, A. R., *Rev. of Gastroenterology*, 18:588, 1951
2. Miller, B. N., *J. So. Carolina M. A.*, 48:1, 1952

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The Strange Case Of the Pink Physician

His record showed an affinity for the red side of the political spectrum. Yet he was assigned to an Army post where strict loyalty was of prime importance. Here's the story of what one newspaper called 'a classic of parlayed stupidity'

By Roger Menges

• The first (and only) time I saw Dr. Sheppard Carl Thierman, he was in hot water. It was in 1949, at a meeting of the local chapter of the Association of Internes and Medical Students at Columbia's College of Physicians and Surgeons.

A medical student had just delivered a burning denunciation of Thierman, who was then the international vice president of A.I.M.S. Thierman's left-wing activities, the student had charged, were reflecting seriously on the association's reputation and good name.

During this attack, Thierman had sat poker-faced, twirling a ring around his finger. It was hard not to feel a twinge of sympathy for the slight, dark, and bespectacled interne.

But he needed no sympathy. For when it came time to answer, he fended off the charges with such coolness and conviction that the accuser himself seemed at fault. So the matter was dropped.

That was more than three years ago. Today, the 31-year-old Brooklyn M.D. is in hot water again. But this

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THE STRANGE CASE OF THE PINK PHYSICIAN

time the accuser is more formidable, the charge more serious. The accuser is the U.S. Army. And the charge is that Thierman used fraud to get into uniform.

The Thierman case is a strange one that raises a number of important questions. It's also an embarrassing one to the Pentagon. For when Thierman applied for a commission in the Medical Corps, he twice refused in writing to answer questions about his loyalty and about possible membership in subversive organizations. But the Army commissioned him a first lieutenant, anyway. What's more, it assigned him to one of the most sensitive spots in the Korean theatre.

Unexplained Assignment

These facts might never have come to light if it hadn't been for Dr. William B. Reed of Washington, D.C. As a medical student, Reed had attended the previously mentioned meeting at Columbia. And since that night back in '49, he'd been conducting an unremitting campaign to expose the denizens of the left.

As part of that campaign, Reed questioned a Baltimore doctor one day last October and asked him what had become of Thierman. There was "real good news" about Thierman, the doctor said; and he suggested that Reed contact a second physician for further details. Reed did, and got this response:

"Oh, haven't you heard? Old



Sheppard Carl Thierman
No reply to loyalty questions

Shep is in the Army and over on Koje Island."

Reed promptly got in touch with Albert M. Colegrove, a staff writer for the Scripps-Howard newspaper chain. The result: a series of newspaper articles calling attention to the fact that "during a period when there were three major riots" on Koje Island, Thierman was present, treating the Communist prisoners of war.

"There has been much speculation," wrote Colegrove, "that the Army's Koje Island hospital contained a secret Red 'message center,' through which instructions from North Korea and Communist China were relayed to Red P.W. leaders who pretended to be ill."

Next came an investigation by the Senate Internal Security Subcom-

THE STRANGE CASE OF THE PINK PHYSICIAN

mittee. That group heard a former F.B.I. agent testify that Thierman had become a dues-paying Communist in 1946. As evidence, the agent produced copies of what was identified as Thierman's accepted application for party membership.

The Senate probers then subpoenaed the physician himself, who meanwhile had returned to this country on rotation. A day-long hearing behind closed doors produced ninety-nine double-spaced typewritten pages of testimony. But most of the ninety-nine pages were filled with Thierman's constant refusal to answer certain questions on the grounds of possible self-incrimination.

Among those questions:

¶ Had he ever been a Communist?

¶ Had he ever engaged in subversive activities?

¶ Had the Communist party ordered him into uniform?

¶ Had he arranged for shipment of penicillin to Indo-Chinese Communists?

Clues from the Past

Nor was Thierman in the mood to talk about his former activities as an officer of A.I.M.S. A few of these activities were described three years ago in this magazine* as follows:

"Dr. Sheppard C. Thierman, 1949 A.I.M.S. vice president, and a dozen or so other A.I.M.S.ters, took

*See "Leftist Minority Woos Future Doctors," March, 1950.

part in last year's World Youth and Student Festival held in Budapest . . . One American student who attended said Dr. Thierman took the occasion to denounce the U.S. delegation there as a 'spy center.' The festival's American delegation, of which Dr. Thierman was co-chairman, issued this portrayal of life in the U.S.:

"The threat of war is hatched in the offices of our Wall Street financial lords . . . More than one-third of us [in the U.S.] are brought up in ugly tenement slums . . . Purge committees, often composed of Negro-haters and open Fascists, censor our textbooks, plunder our libraries, hound progressive teachers, threaten protesting students . . . To the ever-louder demand of our youth for jobs, all Wall Street can answer is 'Join the Army.'"

Repercussions of Thierman's Budapest trip came nine months later, when he was ousted from an internship at Kings County Hospital in Brooklyn, apparently because he was suspected of having communistic tendencies. Shortly after that, Thierman applied for a commission in the Army Medical Corps Reserve. He was called to active duty in the summer of 1951; and from October to May of the following year, he worked in the prisoner-of-war hospital and compounds on Koje Island.

Whatever his previous background, Thierman has denied that he was involved in any form of es-

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THE STRANGE CASE OF THE PINK PHYSICIAN

pionage in Korea. He has stated that he had no contact with Red officials and no political discussions with any of the 44,000 Red prisoners of war for whose health he was partly responsible. He claims to have had no preknowledge of the prisoner riots. "If I had," he says, "I would immediately have reported to the proper authorities."

The Army will probably have to take Thierman's word for this. But it may throw the book at him on a minor technicality: Pentagon officials have hinted that in his application for a commission, Thierman may have misrepresented or concealed essential information.

As of last month, the Army had not yet decided whether to bring Thierman's case to a general court martial. If it did, and if the lieutenant were found guilty, he would face a prison term of up to five years.

Thierman's eventual fate is less important than are some of the issues his case raises. Physicians, both as citizens and medical men, may well ask these questions:

Who was responsible for giving

him a commission and for calling him to active duty?

Who sent him to Koje Island?

Why hadn't anyone in the Army looked into his refusal to answer questions bearing on his loyalty?

Are there any more doctors like Thierman in important Army posts?

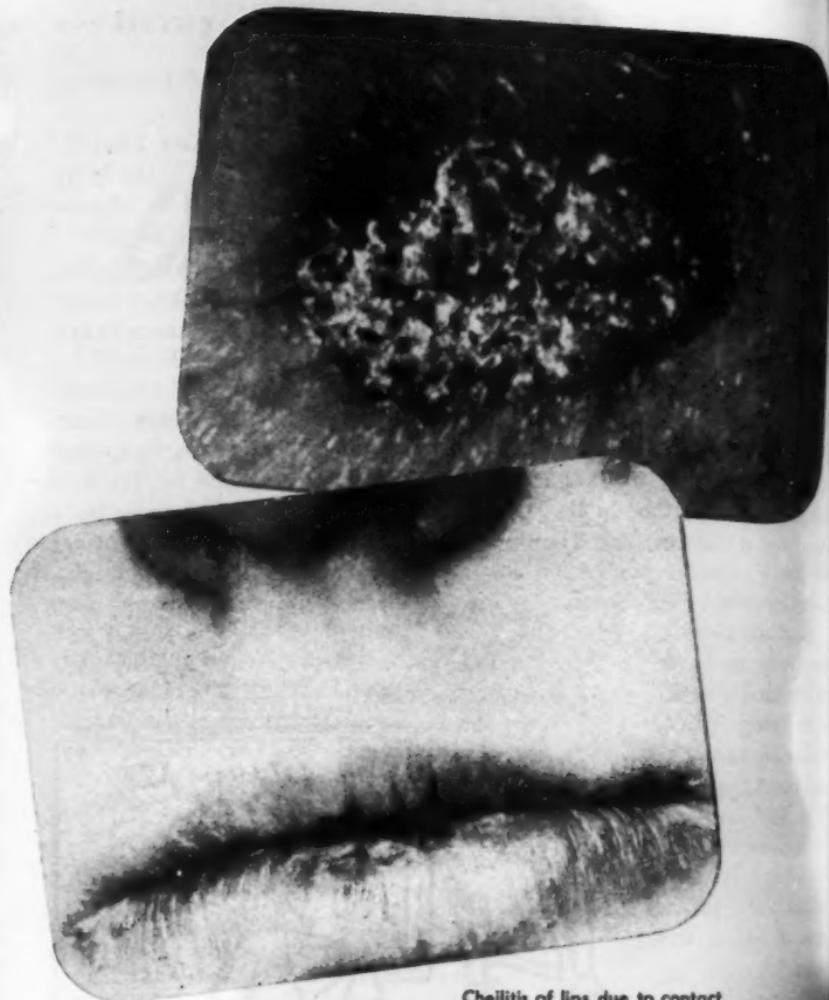
Are there any Thiermans in key spots in the medical profession?

"Whoever is at fault," concludes Senator Herbert R. O'Conor, chairman of the subcommittee that questioned Thierman, "the net result is deplorable." The result may be a shade less deplorable if it furnishes the Army with an incentive to tighten up its security regulations. END

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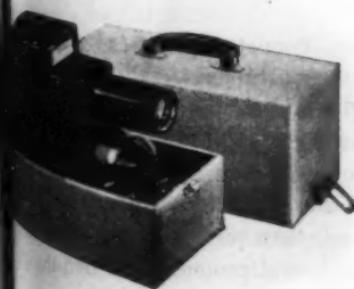
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CARDS CASCADE into the air, and Dr. Zina B. Bennett catches the right one—the king of hearts. Dexterity of this sort brought Bennett the only gold medal that the British Magical Society has ever awarded to an American conjuror.

Doctor of Magic

● Magician Zina B. Bennett finds that his card tricks are just what the doctor ordered. And who's the doctor? Zina B. Bennett.

In his dual capacity, Bennett is both superintendent and top entertainer of the Michigan Mutual Liability Company's industrial hospital in Detroit. As superintendent, he heads a staff of sixty; as "practicing necromancer," he has brought cheer to hundreds of patients.

One of the tricks they go wild about: The patient picks a card, any card, then puts it back in the deck. Bennett riffles the cards and propels them into the air. One card sticks to the ceiling. Which card? The patient's, of course.



A PATIENT FORGETS both crutches and convalescence as he concentrates, for one magic moment, on the king-size cards that Dr. Bennett fans out. Of all the tricks in Bennett's bag of them, those with the giant cards are most popular.

"An old hand at sleight-of-hand," Bennett calls himself. And it's no exaggeration. He began studying magic as a boy and has since won world-wide recognition by adding several gimmicks of his own creation to the conjuror's bag of tricks.

He lays claim, for example, to being one of only two living men who can whip a deck of giant (7" x 4½") cards through a whirlwind now-you-see-it-now-you-don't sequence. The other practitioner is a Bombay Indian; "and he learned it from me by mail," says Bennett.

He often unveils the secrets of simple coin-manipulation tricks to his patients—especially to those with injured hands. "The tricks keep them occupied," he says, "and help to loosen stiff fingers. It's a good combination of physiotherapy and psychotherapy." **END**

ACTH



**LESS THAN
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Patients at almost every income level can now afford either Corticotropin Solution Wilson or Purified Corticotropin-Gel Wilson.

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Don't Say Osler Didn't Warn You!

Many hard-driven M.D.'s today haven't mastered the still-timely advice on self-management he gave the world forty years ago

By Helen C. Milius

- Are you courting a coronary with tension and over-work? And do you insist that barefaced shirking is the only alternative?

You're contradicted by no less an authority than the late Sir William Osler.

Practitioner, professor in four universities, author of the book that's still a medical "bible," Osler nevertheless avoided the rat-race that amounts to delayed-action suicide for many of today's physicians. How?

By being a genius, you grumble. Yet maybe not. He described his "brains" as "of the most mediocre character." He attributed his accomplishments to "just habit, a way of life."

Osler explained this very vital habit in a talk to Yale students exactly forty years ago this month—on April 20, 1913. The speech was published later in a little 52-page booklet.*

Is it obsolete in this more hurried half of the century?

Test it yourself. Bring up the nagging complaints that hagride you these days, and you'll find in Osler's advice the equivalent of a sympathetic preventive check-up. For example:

[MORE→]

*A Way of Life. Harper & Brothers, New York. 1937.

when patients are



or "unstrung" ---

TRANQUILIZER...RELAXANT...ANTIDEPRESSANT

Mabutone

Original

TABLETS AND ELIXIR

Each tablet or spoonful
(5 c.c.) contains:

Mephenesin 250.0 mg.
d-Amphetamine phosphate
(dibasic) 2.5 mg.
Butabarbital 8.0 mg.

Bottles of 50, 100, and 1000 tablets.
Elixir: Bottles of 8 oz.

TRIPLE-ACTING to produce
neuromuscular relaxation and
promote tranquility, thus breaking
the chain of fatigue, aches and pains,
depression, and the numerous other
symptoms associated with tension.



A PRODUCT OF REED & CARNICK
A trusted name since 1860 JERSEY CITY 6, N.J. TORONTO, ONT., CAN.

DON'T SAY OSLER DIDN'T WARN YOU!

Do you feel that you're working under too much pressure? Then understand this, says Osler:

"One of the saddest of life's tragedies is the wreckage of the career . . . by hurry, hustle, bustle, and tension . . . Concentration, by which is grown gradually the power to wrestle successfully with any subject, is the secret . . . The failure to cultivate the power of peaceful concentration is the greatest single cause of mental breakdown . . .

"Realize how much time there is, how long the day is. Realize that you have sixteen waking hours, three or four of which at least should be devoted to making a silent conquest of your mental machinery."

Down With Hurry

You mutter that you can't afford to spend that much time cultivating your mind? Then Osler reminds you that you can't afford *not* to:

"Control of the mind as a working machine, the adaptation in it of habit, so that its action becomes almost as automatic as walking, is the end of education—and yet how rarely reached! It can be accomplished with deliberation and repose, never with hurry and worry . . .

"Aristotle somewhere says that the student who wins out in the fight must be slow in his movements, with voice deep, and slow speech; and he will not be worried over trifles which make people speak in shrill tones and use rapid movements."

But there are so many lessons to be learned and there's so much planning to be done, you object. To which Osler replies:

"The chief worries of life arise from the foolish habit of looking before and after . . . The petty annoyances, the real and fancied slights, the trivial mistakes, the disappointments, the sins, the sorrows, even the joys—bury them deep in the oblivion of each night . . .

"Many a man is handicapped . . . by a cursed combination of retro- and intro-spection, the mistakes of yesterday paralysing the efforts of today . . . To look back, except on rare occasions for stock-taking, is to risk the fate of Lot's wife . . . The load of tomorrow added to that of yesterday, carried today, makes the strongest falter."

Keep Eyes on Today

Here, Osler quotes Carlyle to you:

"‘Our main business is not to see what lies dimly at a distance, but to do what lies clearly at hand’ . . . Waste of energy, mental distress, nervous worries dog the steps of a man who is anxious about the future . . . The way of life that I preach . . . is the practice of living for the day only, and for the day’s work, *Life in daylight compartments*.”

If you just can't seem to climb out of the rut of daily routine, Osler offers a suggestion:

"Let no day pass without contact with the best literature of the world



RAYTHEON Radar *Microtherm* offers you the modern microwave method of precision heat application.

MICROTHERM operates at 2-150 megacycles, as contrasted with the highest television range of 50 megacycles, hence *TV interference is avoided*.

MICROTHERM provides penetrating energy for deep heating—dosage may be accurately applied as well as clinically efficient.

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clinically confirmed
esthetically acceptable
for simple
dependable contraception

A tube of Preceptin Vaginal Gel is shown lying diagonally across the frame. The tube is white with the brand name "Preceptin" written in a large, elegant script font, and "VAGINAL GEL" in a smaller sans-serif font below it. A small amount of gel has been dispensed from the open end of the tube, revealing a white applicator tip with a black band near the base. To the left of the tube, there is a shield-shaped logo for Ortho, featuring a caduceus symbol (a staff with wings) above the word "Ortho". Below the tube, there is some very small, illegible text.

PRECEPTIN® vaginal gel contains
the active spermicidal agents
p-Diisobutylphenoxypropoxyethanol
and ricinoleic acid in a synthetic
base buffered at pH 4.5.

Ortho Pharmaceutical Corporation
Raritan, New Jersey

... Fifte
by day wi
the great
wish to b
the great
moral rad
For a
philosoph
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The fu
tomorrow
vation is

for routine postpartum care

Triple Sulfa Cream

TRADE MARK



Triple Sulfa Cream

Ortho Pharmaceutical Corporation
Raritan, New Jersey



multiple
sulfonamides*
to combat vaginitis

patients report†

- "no discomfort" •
- "no odor" •
- "a clean feeling" •
- "much less soreness" •

* Sulfinosalicylic, N'-acetylsulfonamide,
N'-benzylsulfonamide, Urea Paracide.

† Palm, J. M.: Am. J. Obst. & Gynec., 61:680, 1953.



DON'T SAY OSLER DIDN'T WARN YOU!

... Fifteen or twenty minutes day by day will give you fellowship with the great minds of the race . . . You wish to be with the leaders—know the great souls that make up the moral radium of the world . . . "

For a summary of Sir William's philosophy, keep these few sentences in a convenient nutshell:

"The future is today—there is no tomorrow. The day of a man's salvation is now—the life of the pres-

ent, of today, lived earnestly, intently, without a forward-looking thought, is the only insurance for the future.

"Let the limit of your horizon be a twenty-four hour circle . . . With the mind directed intensely upon the subject in hand, you will acquire the capacity to do more and more, you will get into training; and once the mental habit is established you are safe for life . . ." END

Hot Seat

• A colleague of mine was driving home from a middle-of-the-night house call when his headlights caught a hitchhiker. Ordinarily, the doctor wouldn't have stopped, but this time he acted on impulse and pulled over. In climbed one of the most unsavory-looking characters he'd seen.

"Goin' far, bud?" he asked the doctor, as they sized up one another.

"I don't know yet," replied the doctor, with some truth.

For several minutes they sped through the darkness. Then, the stranger spoke again. "You know, there ain't many guys that would've picked up a guy like me in the middle of the night."

"No?" said the doctor, thinking fast. "Well, I'm different. I'm not afraid of picking up any son of a gun that draws breath, and you know why? This car is 'rigged'."

"Rigged?" the man shot back.

"Sure," said the doctor. "Right now there's a .45 pointed at your back, and I can fire it three ways."

There was a long silence as they rounded a curve and approached a well-lighted filling station.

"Say, bud," the stranger said, "Stop, will ya? I think I'd like to get out here."

—PAUL S. WILLIAMS, M.D.

NOW an automatic wound clip
applier equal to your skill
and speed



AUTOCLIP® APPLIER AND REMOVER

All the advantages of wound clip skin closure—*faster healing, better cosmetic effect, minimum of tissue trauma, easy clip removal*—with the Autoclip Applier, a responsive, dependable instrument that gives greater efficiency and speed to wound closure.

FASTER APPLICATION, POSITIVE ACTION—Based on the standard Michel technic, the Autoclip Applier is fast and positive. Autoclips can be applied to the skin as rapidly as the edges of the wound can be proximated ...the surgeon can concentrate on the actual closure. Cosmetic results are better.

FOR EMERGENCIES—The compact Applier weighs only two ounces—can be carried loaded and sterile in your bag always ready for use. When using the Autoclip Applier, nursing assistance is not required. The Autoclip Applier holds 20 Autoclips—(18mm.). Autoclips are double wound clips; fewer are needed.

For complete description, write for Form 531.

AUTOCLIP Applier 4½" x 1½" x ½", rustless, chrome plated,	\$23.50
AUTOCOILS 18mm., 20 nickel silver double clips per rack	
100 clips (5 racks) to a box	\$2.40
1000 clips (10 boxes) to a carton	\$22.00
AUTOCLIP Remover, 4", stainless steel	\$6.00
Quantity Discounts 5M-5%, 10M-10%	

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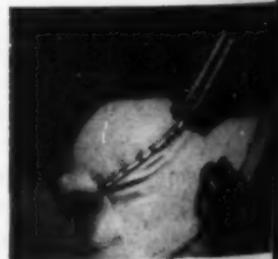
141 East 25th Street, New York 10, N.Y.



Rack of 20 Autoclips is speedily loaded into magazine.



Autoclip Remover for quick, painless removal of Autoclips.



Clipping towels to skin—another important use for Autoclips.

NOW IN BOOK FORM!

Your Economic Weather Vane

[CONTINUED FROM 152]

The known distribution of physicians by three key variables: community size, geographic area, and years in practice. But it included a somewhat too great proportion of full specialists in relation to partial specialists and general practitioners. So, by means of a system of random discarding that preserved the close correlation with the other three variables, a number of questionnaires from full specialists were removed.

5,000 in Sample

The sample thus arrived at contained 5,009 questionnaires. Of these, 4,288 were returns from independent doctors (i.e., those who derive more than half their net income from non-salaried practice). Except where otherwise qualified, the survey breakdowns are based on the replies of these independent practitioners alone.

Results of the survey are being presented, several topics a month, in MEDICAL ECONOMICS. Breakdowns are made by such factors as years in practice, city size, geographic area, and specialty. The survey results are also being published in booklet form.

END

This is a condensation of a more detailed discussion of the purposes and methods of the seventh MEDICAL ECONOMICS Survey. For the full text, see the October, 1952 issue.

Letters to a Doctor's Secretary



In this new volume, MEDICAL ECONOMICS has assembled its complete, step-by-step course of instruction for the physician's aide. Sixteen chapters cover such topics as:

Handling patients	Case histories
Telephone technique	Bookkeeping
Medical terminology	Collections
Office routine	Medical ethics

Bound between handsome, black laminated covers, with the title stamped in gold, this convenient pocket-size book contains 75 information-packed pages. Prepaid price: \$2.

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Medical Economics, Inc. Rutherford, N.J.

Please send me "Letters to a Doctor's Secretary." I enclose \$2.

Name (please print)

Street

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a simpler and safer way to relieve
what your patient calls . . .

"Stuffy head"

You know when . . . and which . . . nasal instillations are desirable. But, the patient who wants relief from a "stuffy head" . . . does he consider such things as rebound congestion, ciliary damage or other hazards of indiscriminate self-treatment?

Novahistine, *taken orally*, usually reduces nasal congestion promptly. It can eliminate use of topical applications between office visits and "overtreatment" by the patient.

The vasoconstrictor agent⁽¹⁾ in Novahistine causes no cerebral excitement and does not lose effectiveness with repeated dosage. Its decongestant action is potentiated and supplemented by one of the most effective, least-toxic of the histamine antagonists.⁽²⁾



NASAL
DECONGESTION
WITH
ORAL DOSAGE

NOVAHISTINE[®]

ELIXIR • TABLETS

Each teaspoonful or tablet provides:

(1) Phenylephrine hydrochloride, 5.0 mg.
(2) Prophenpyridamine maleate, 13.5 mg.

PITMAN-MOORE COMPANY

Division of Allied Laboratories, Inc. • INDIANAPOLIS, INDIANA

*TRADEMARK

A Scientific Yardstick for Setting Fees

[CONTINUED FROM 105]

He adds that non-surgeons tended to agree with surgeons anyway in their answers to his questionnaire—and that, in the final analysis, the extremes balanced out.

A 'Fair Formula'

For every criticism of Horton's study, expressed by participating doctors, there were several rounds of applause. One M.D., for example,

offered "sincere congratulations on developing objective methods for arriving at a fair formula."

Horton himself is pleased with the results. He cautions, however, that the index must be considered as applying only to the "average uncomplicated procedure." And he doesn't claim that he has found *the answer, the index*. He admits that his study so far is fragmentary, that it has a regional flavor, and that it touches no branch of medicine but surgery. Yet Dr. Horton feels certain that he has hacked out at least the beginning of a path in the right direction.

END

Who Got the Edge?

- When I answered the doorbell, I found an elderly woman who explained that she had been my husband's patient. "I've owed him \$3 for two years," she said, "and I just haven't got the money. But I tat, and I'd be glad to pay off the \$3 by doing some tatting for you."

I told her I'd be happy to accept the tatting as payment. So a few days later she returned to deliver it. After I'd thanked her, she added, "And here's some red edging I made for your baby girl."

I was profoundly touched and told the woman so. Then, as she turned to leave, she said, "Do you *really* like the edging?"

I assured her that I did.

"And you want to keep it?"

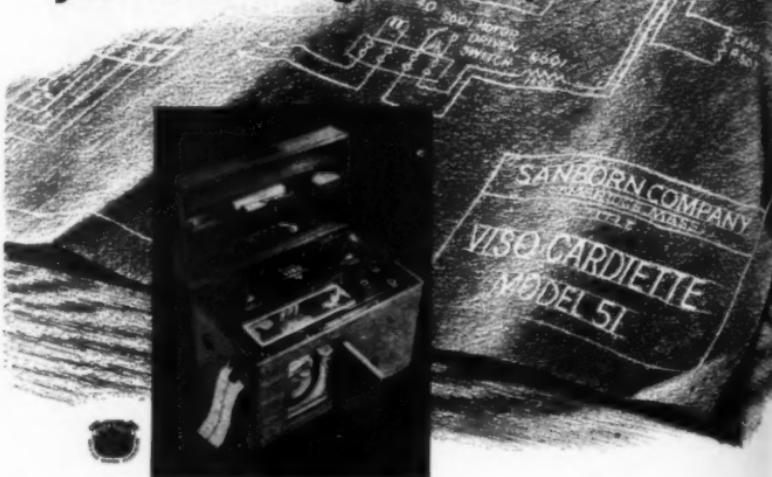
"Oh, yes," I replied.

"Well, there's three yards there, and I get \$1 a yard for it. So now *you* owe me \$3."

I paid.

—BLANCHE H. HODGE

Here is an electrocardiograph
built to provide the
continuity of service
you have a right to expect



While it is important that your ECG be Accepted by the AMA Council on Physical Medicine and Rehabilitation, it is of equal and perhaps greater consequence to you that it also be designed and constructed to maintain these performance standards in continuous service.

The VISO-CARDIETTE is designed first of all to exceed the Council's requirements concerning the instrument's recording characteristics. And then, the highest quality purchasing and production control assures the maintaining of that performance in each instrument long after it has left the factory.

For example, all purchased components selected for use in the Viso are of precision instrument quality,

and all are chosen for their *continuity of service* rather than their initial cost. Also, every component in each assembly and every assembly in each instrument, as well as the completed instrument itself, are all thoroughly checked to rigid Sanborn specifications as they move along the production line.

In addition, VISO-CARDIETTE construction is guided by electronic and mechanical experts who know from long experience that electrocardiography demands an instrument of only the highest quality performance.

Yes, you can expect Continuity of Service with a VISO-CARDIETTE.

A new booklet, "Check Lists for Buyers of ECG's" offers guidance in evaluating the various instruments available. A copy will be sent simply on your request.

Makers of fine ECG's since 1924

Sanborn Company 

CAMBRIDGE 39, MASSACHUSETTS

Physicians May Scrap Service-Type Health Plan

[CONTINUED FROM 115]

scale. "The average-fee plan," it says bluntly, "can be made to work only if each physician forgoes the traditional practice of setting his fee on the basis of ability to pay."

The committee also proposes that local medical societies publicize a conclusion stemming from the recent study conducted for the C.M.A. by Psychologist Ernest Dichter—namely, that most physicians already have a set of fees they charge as a rule for the commoner procedures, and that they tend to base their fees less on the patient's ability to pay than on what they have become accustomed to charging. Although this conclusion was derived from a very small sample of doctors, the committee apparently feels that it is valid—valid, at least, in its own state. So, indirectly, the doctor who maintains a sliding scale may find himself squeezed between two disapproving bodies: organized medicine and the general public.

How Much Freedom?

Won't the publicity to be given the average-fee schedule seriously interfere with the physician's right to set his own fees?

There may be some tendency in this direction—but proponents of the plan insist it will be slight. Ac-

tually, they say, the C.M.A. doesn't intend to publicize fees as such. The average-fee schedules won't be given general circulation; they'll simply be available to patients who want to check a doctor's charge against the prevailing fee.

Generally speaking, the purpose of medical-society publicity will be threefold: (1) to urge patients to discuss fees in advance; (2) to publicize the fact that most physicians have set a standard fee for all patients; (3) to emphasize that the doctors maintain fee-complaint machinery for the protection of the patient.

When Patients Complain

How far will the medical society go in backing up patients who complain against doctors?

Probably at least as far as some grievance committees already go.

The complaint department, of course, will enter the picture only if a patient lodges a formal protest against a doctor; and it will be up to the patient to prove that the doctor has charged a higher-than-usual fee *without prior agreement*.

But if the medical society becomes convinced that a patient has been overcharged, it will ask the physician to reduce his fee. If he refuses and takes his case to court, the society will back the patient.

What about fee complaints from patients who have no health insurance or are insured by organizations other than C.P.S.P.?

[MORE→]

Announcing
a new antibacterial combination



Gantricillin is the new combination of Gantrisin 'Roche' (the single, more soluble sulfonamide) plus penicillin.

Gantricillin is recommended for infections susceptible to penicillin or sulfonamides. It is especially useful when the causative organisms are more susceptible to the combination than to either drug alone. Each scored tablet contains 0.5 Gm Gantrisin and 100,000 units of crystalline penicillin G potassium.

Hoffmann-La Roche Inc., Nutley 10, N. J.

GANTRISIN®—brand of sulfisoxazole
GANTRICILLIN™

PYHICIANS MAY SCRAP SERVICE-TYPE PLAN

It will make no difference whether the patient has Blue Shield, some other type of health insurance, or none at all. The medical society, it's claimed, will offer *all* patients the same protection.

These, then, are the main points in a probable new experiment in voluntary health insurance—an experiment that could revolutionize the entire practice of fee setting.

What are the long-range implications of the program? According to Dr. Wilbur Bailey, chairman of the A.M.A. committee that drew up the plan, it can be expected to have a twofold effect:

1. It will let patients know in advance the cost of medical procedures.

2. It will serve as a barrier to "those who are bringing compulsory health insurance upon the profession." As a corollary, it will shore up the voluntary health insurance structure.

3. It will supplant the Blue Shield service-type plan, which has been criticized increasingly by doctors and patients alike.

4. It will help Blue Shield and the private insurance carriers to compete on more even terms with the closed-panel plans. END



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"Gad, what a doctor. He prescribed a new wife and two shots of bourbon before each meal!"

Relative Urinary Solubility of Sulfonamides

The triple sulfapyrimidine mixture (Meth-Dia-Mer) excels in low toxicity and particularly in free urinary excretion. Its solubility in acid urine, the chief problem in excretion, is much higher than that of any single sulfonamide of comparable potency. Penicillin and triple sulfonamide mixtures are being increasingly used by physicians

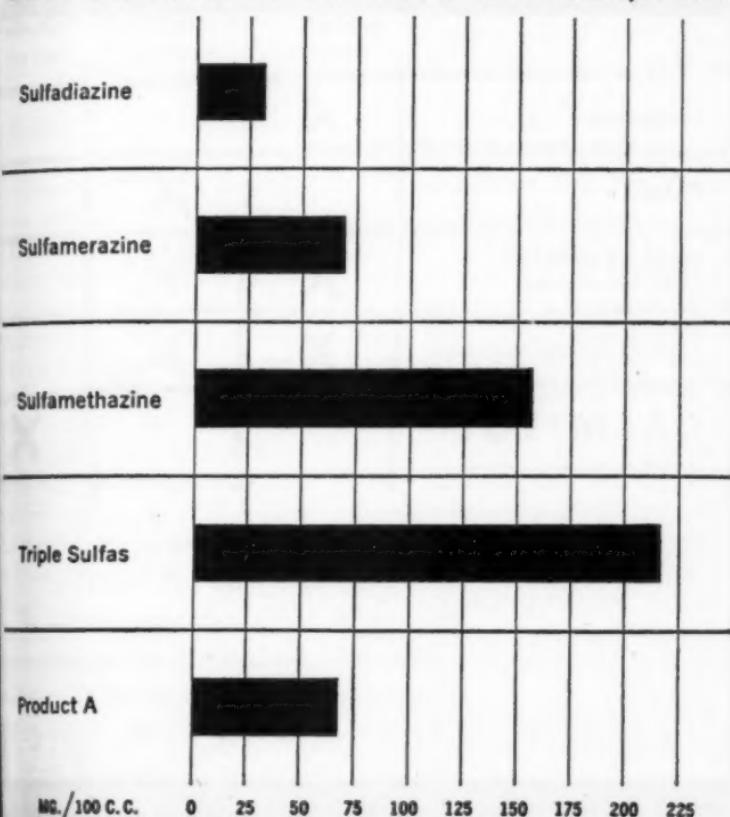
Approximately 13 billion tablets of sulfapyrimidines have been given—intolerance has been very rare.

Have you received your copy of
THE SULFAPYRIMIDINES?

This monograph, beautifully leather-bound, may be requested from the detail men of any ethical house calling on you; or, if you prefer, we will send you a copy immediately upon request on your professional stationery.



COMPARATIVE URINARY SOLUBILITY OF SULFONAMIDES IN ACID URINE (pH 5.0)



Biamonte, A. R. and Schneller, G. H.: J. Am. Pharmaceutical Assoc., Scientific Edition, 41:341 (July) 1952.
Gilligan, D. R. and Plummer, N.: Proc. Soc. Exper. Biol. & Med., 53:142 (June) 1943.

*Advertisement is presented on behalf of the ethical
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ALCO CHEMICAL DIVISION

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Antipruritic Scoreboard

	relatively ineffective	dangerously sensitizing	effective and safe
Calamine	X ^{1,2}		
Phenol		X ^{3,4}	
Local Anesthetics of the "caine" group	X ¹	X ⁵	
Topical Antihistaminics	X ¹	X ⁵	
CALMITOL			X*

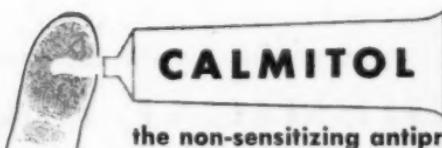
Calmitol avoids the therapeutic pitfall of sensitization. Safe and effective, the specific antipruritic ingredients of Calmitol—camphorated chloral, hyoscyaminooleate and menthol—raise the threshold of skin receptors and sensory nerve endings stopping pruritus at the point of origin.

1. Lobitz, W. C., Jr., and Jillson, O. F.: Postgrad. Med. 12:2, 1952.
2. Goodman, H.: J.A.M.A. 129:707, 1945.

3. Underwood, G. B., et al.: J.A.M.A. 130:240, 1946.

4. Lubowe, I. I.: New York State J. Med. 50:1743, 1950.

5. Nomland, R.: Postgrad. Med. 11:412, 1952.



the non-sensitizing antipruritic

Thos. Leeming & Co. Inc. 155 East 44th Street, New York 17, N.Y.

There's No Ballyhoo Like Chiropractic Ballyhoo

CONTINUED FROM 134]

stitutional broadcasting emphasizes general health education, no such selfless zeal dilutes the chiropractors' message. Their sole reason for going on the air is to get business—and they make the most of it.

Yet their talks are often *not* listed in advance as chiropractic lectures. One series, for instance, was disarmingly billed as "Miracles in Health." Some medical men clamor for legal action to stop this fraudulent huckstering over the air waves. What they apparently don't realize is that the Federal Communications Commission can't pre-censor a broadcast.

The F.C.C. can, to be sure, deny renewal of license to a station not operating in the public interest. But such action would hardly be reasonable in the case of a reputable station whose only offense was an occasional few minutes of chiropractic promotion.

Tabloids of the Trade

In the magazine and booklet fields, the chiropractor makes the meat-medicine sensationalism of all a century ago seem pallid. A typical example is a twenty-four-page tabloid put out by the Spears Clinic in Denver.

The front page of a recent issue

of this publication pictures a drum majorette with legs like Dietrich's. As the result of chiropractic treatment, says the caption, she made a complete recovery from multiple sclerosis. Another feature, on an inside page, is headed "Multiple Sclerosis Conquered." It gives the reader to understand that the Spears Clinic was the sole agency to diagnose the disease, as well as cure it.

As a matter of fact, this lively tabloid illustrates case histories of just about every type imaginable. It gives names and addresses of patients, too. Emphasis is placed on such sound scientific techniques as X-rays and blood sedimentation tests. Cures and functional restorations are reported in cases of cerebral palsy, cancer, Buerger's disease, "insanity," epilepsy, "tubercular hip," infantile paralysis, asthma, hemorrhoids, etc. One client, says a headline, was "relieved of sixteen ailments."

And all this in only one issue!

Cheerful news and edifying art for many such publications are supplied by "Most Beautiful Back" contests. These are a common feature of chiropractic conventions. Attractive participants, appropriately draped, vie for the title of "Miss Chiropractic," while eyes and flash bulbs pop.

Headline Snagging

Often, this material finds its way into the general press. For chiropractors don't confine their journal-

...specify

ABBOTT'S
new Oral Anti-biotic

EIT

(Ery-

INDICATIONS

Pharyngitis,
acute pneumo-
nitis caused by
streptococci and
staphylococci.

DOSAGE

Total daily dose
the infection
adequate in
For the average
doses of
every four to

For severely
six-hour in
response shou
organism is su
in 48 hours a

McGuire et al.
Wilson et al.
16, 3, Hain
227, Aug.

Especially effective against gram-positive organisms resistant to other antibiotics.

Low toxicity; reported side effects infrequent.

Special "high-blood-level" coating.

ERYTHROCIN, 0.1-Gm. (100-mg.) Tablets, bottle of 25.

ERYTHROCIN

TRADE MARK

(Erythromycin, Abbott)

INDICATIONS

Pharyngitis, tonsillitis, scarlet fever, erysipelas, pneumococic pneumonia, osteomyelitis, pyoderma. *Also other infections caused by organisms susceptible to its action, including streptococci, streptococci and pneumococci.*

DOSEAGE

Total daily dose of 0.8 to 2 Gm., depending on severity of the infection. A total daily dose of 0.6 Gm. is often adequate in the treatment of pneumococic pneumonia.

For the average adult the initial dose is 0.2 Gm. to be followed by doses of 0.1 or 0.2 Gm. followed by doses in the same range every four to six hours.

For severely ill patients doses up to 0.5 Gm. may be repeated every six-hour intervals if necessary. Satisfactory clinical response should appear in 24 to 48 hours if the causative organism is susceptible to ERYTHROCIN. Continue therapy for 48 hours after temperature returns to normal. *Abbott*

McGuire et al. (1952), J. Antibiotics & Chemo., 2:281, June.

Holloman et al. (1952), Proc. Staff Meet. Mayo Clin., 27:385,

and M. J. Haight and Finland (1952), New Eng. J. Med.,

252, Aug. 14.

Evenflo—Ideal for Premature and Normal Baby

Two Outstanding Nipples

**Evenflo® TWIN AIR-
VALVE NIPPLE
for colic-free,
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The twin valves in the base of the patented Evenflo Nipple admit air into bottle as baby nurses. This keeps pressure normal inside the bottle and provides smooth, colic-free precision feeding.

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*The Dr. Griesinger
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The new Dr. Griesinger Nipple is the result of an orthodontist's search for a means to help prevent crooked teeth. Dr. Griesinger's solution is a nursing nipple of an entirely new shape designed to aid the expansion and correct relationship of the dental arches in the formative months following birth. If your pharmacist cannot supply this new ethical product, please write us. Professional sample upon request.

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Here is a truly "broad spectrum" weapon for combating vitamin B complex deficiency wherever it is present or may develop.

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Each teaspoon (5 cc.) supplies:

Thiamine hydrochloride.....	1 mg.
Riboflavin.....	1 mg.
Niacinamide.....	10 mg.
Pyridoxine hydrochloride.....	0.2 mg.
Panthenol.....	1 mg.
Choline.....	50 mg.
Inositol.....	20 mg.
Vitamin B ₁₂ (crystalline).....	0.33 mg.
Folic acid.....	0.2 mg.
Biotin.....	0.02 mg.
Para-aminobenzoic acid.....	0.5 mg.
Soluble liver fraction N.F.....	300 mg.
Ferrrous sulfate (no supply 7.5 mg. iron).....	37.3 mg.



Each capsule supplies:

Thiamine hydrochloride.....	1 mg.
Riboflavin.....	1 mg.
Niacinamide.....	10 mg.
Pyridoxine hydrochloride.....	0.2 mg.
Calcium panthothenate.....	1.2 mg.
Choline.....	50 mg.
Inositol.....	20 mg.
Vitamin B ₁₂ (crystalline).....	0.33 mg.
Folic acid.....	0.2 mg.
Biotin.....	0.02 mg.
Para-aminobenzoic acid.....	0.5 mg.
Desiccated liver N.F.....	300 mg.
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POLY-VI-SOL® Each 0.6 cc. supplies	5000 units	1000 units	50 mg.	1 mg.	0.8 mg.	5 mg.
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MEA

CHIROPRACTIC BALLYHOG

little ingenuity to their own news organs. They know how to hit the regular newspapers, too.

The idea of sending releases to newspapers isn't, of course, original with chiropractors. Many medical societies have been doing it for years. But medical news releases are sent out more often than not under such general titles as "Proper Shoe Fitting Is Important" or "Everyone Should Eat a Hearty Breakfast." Items of that type do virtually nothing to bring patients to doctors' offices. The chiropractic releases, on the other hand, are pointedly specific: "No More Insulin for Mrs. Gubellman"; "Kansas Man Gets Rid of Gallstones"; and the like. Each such story states that the cure occurred after chiropractic adjustments.

Every practitioner is asked to send to the National Chiropractors Association the address of every weekly newspaper in his county. Then chiropractic releases are aimed for the greatest local effect.

Even when chiropractic is criticized, newspapers often get the story directly from chiropractic sources. The point of any such item: Some "un-American" group is trying to deny Americans their right of free choice of healer. Thus, when medical men oppose any proposed law that would make life easier for chiropractors, their opposition is represented as proof of the machinations of doctors' monopoly.

This ability to make palatable

lemonade out of the lemons thrown at them is one of the real talents of chiropractic publicists.

Lobbying Jamboree

In their approach to state legislatures, chiropractors have been phenomenally successful. They've persuaded the lawmakers of forty-four states to give them some measure of recognition.

In pleading their case, they're masters at the game of tailoring all arguments to suit the immediate situation. If, for example, the state has no law licensing chiropractors, they point out that they're in business anyway—but without regulation. So why not be realistic? Why not control the practice by recognizing only the "well-trained and competent" chiropractors?

If, on the other hand, a state requires them to pass medical examinations, they protest against having to conform to "doctors' rules." And if there's a composite board of examiners, they yell, "Discrimination!" because the chiropractors on the board are apt to be outnumbered by M.D.'s.

Their legislative goal in each state is, of course, a state board of chiropractic examiners—with no nonsense about pre-professional training or basic sciences for the candidates. Toward this end, they rely heavily on their lay organizations, which are usually happy to apply pressure.

When it comes to participation in community activities, the chiroprac-

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CHIROPRACTIC BALLYHOO

ers don't miss a trick. Wherever possible, they join Rotary and Kiwanis clubs, veterans' groups, and similar organizations. They're willing to serve on committees and to run for office. And they gladly help solve program problems by exhibiting "before-and-after" chiropractic films.

In line with their interest in veterans' organizations—an activity in which physicians generally aren't conspicuous—they even managed, not long ago, to elevate one of their number to the American Legion's national executive committee. So it isn't strange that, in 1950, the Legion went on record as urging the Veterans Administration to make chiropractic benefits available to veterans.

Chiropractors who served as enlisted men in the armed forces are organized as the American Society of Military Chiropractors. The designation implies, without saying so, that the Army, Navy, and Air Force use chiropractic and that the society's members served as medical officers.

Physicians active in the Legion's rehabilitation program may not be able to resist chiropractic pressure much longer if they don't get the support of M.D.-members of local posts and of M.D.-veterans generally. So far, physicians in general have been both insensitive and inarticulate about the dangers of Government-authorized chiropractic treatment of veterans.

Still another patriotic area in which these cultists are eager to participate is civil defense. The imagination may boggle at the notion of an emergency chiropractic adjustment for a bombing victim; yet many a civil defense team is in a position to provide just that, should the occasion arise.

Recruiting Tactics

Solicitation of prospective students is one of the chiropractors' chief propaganda projects. Why are they so eager to recruit potential competitors? Because the recruiting drive is one more means of telling the world about the wonders of chiropractic; and because the more chiropractors there are, the more powerful their organization.

Solicitation is pretty much at the trade-school level. For example, a recent advertisement of the Beabout College of Chiropractic is headlined, "Wonderful Opportunity!" Then follows the familiar patter: "If you are ambitious, want to become a professional man or woman, want a bigger income . . ." And so on.

Another ad begins: "Get Out of the Rut . . . Get into a Profession . . . Be Your Own Boss . . . Earn Real Money."

A chiropractic "college" that can't get a charter as an educational institution can often operate legally on a trade-school license. And it's only fair to point out that most of these make a practical gesture toward giving students their money's worth—

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in Organon's cap*



Intrinsic Factor

Organon's long list of achievements has been capped with the development of a reliable intrinsic factor preparation — for the first time guaranteeing oral vitamin B₁₂ absorption for *all* patients. Just two tiny Bifacton* tablets (Vitamin B₁₂ with Intrinsic Factor Concentrate) constitute 1 U.S.P. anti-anemia unit — sufficient to maintain a pernicious anemia patient for an entire day. Never before have physicians had available a reliable oral anti-anemia preparation of such concentration and potency — never before have they had assured vitamin B₁₂ absorption for all patients. Bifacton is available in boxes of 30 tablets.



*Patent Pending

Organon INC. • ORANGE, N. J.

CHIROPRACTIC BALLYHOO

featuring, in the "professional curriculum," a course in salesmanship.

Boosts From M.D.'s

Chinks in the physician's armor give the chiropractor welcome openings. A recent throw-away contains such significant statements as:

| The patient went to the chiropractor because the doctor was too busy;

| The hospital refused to admit the child;

| The doctor tried to prescribe over the phone;

| The doctor refused to make a house call or a night call.

Most chiropractors view physicians as their mortal enemies. But they're delighted to make use of any endorsement by an M.D. And, believe it or not, they do occasionally get one.

Such an endorsement may, of course, be a phony. One cultist, for example, was "certified" as a "Master Diagnostician" by the school he owned. Abbreviating this to "M.D." he was able to pontificate impressively on the merits of his system of healing.

But sometimes the endorser is a genuine M.D.—possibly well along in his dotage, but with all credentials in order.

Even so, favorable comment from medical sources is so scarce that chiropractors have had to become skillful in manufacturing imitations. For example, an undated issue of the Spears Chiropractic Sanitarium

News ran an item beginning: "After long years of the medical profession's denial of merit in chiropractic, it is refreshing to read the following in MEDICAL ECONOMICS": It then quotes a news report of an M.D.'s plea that physicians pay more attention to physical medicine!

Physicians sometimes complain about medical society dues. They have also been known to grumble because their societies don't *do more*—forgetting that to do more, the members must be willing to spend more.

Chiropractors accepted the fact long ago that they must up the ante in order to up the benefits. The Indiana Federation of Chiropractors, for instance, collects \$240 a year from each member. Most of the money goes to support the manifold promotional activities of the trade; some is spent to help extricate individual members from legal entanglements.

There's no escaping the fact that the chiropractic associations do a highly effective job in terms of service to members. If their energy, shrewdness, money, and devotion were used in a better cause, the M.D. would have to give them his unstinting admiration.

As it is, in these days of booming practices, some medical men shrug off the chiropractor as a minor nuisance; they dismiss his doctrine as a joke. In doing so, they lose sight of the implication in many a patient's tombstone epitaph: that there's nothing funny about dying. END

News

An 'easy solution' to fee splitting • Hall

of fame for surgeons • Panel cuts fee complaints one-third

Flaws in multiple screening • Reed-Keogh prospects 'good'

Doubts value of mass chest X-rays

Society Head Says Poor Turnout Elected Him

Medical leaders talk about poor attendance at meetings, as they talk about the weather. But they seldom do anything about it.

Something *will* be done about it, though, in St. Louis, if the new president of the St. Louis County Medical Society, Dr. Guy N. Magness, has his way.

To explain his concern over the problem, he interpolated in his recent presidential address an analysis of "regrettable" fact. "The officers you have installed this evening," he said, "were elected by approximately 20 per cent of the membership."

According to the society's constitution, Magness explained, doctors must attend "at least two scientific meetings in order to be eligible to vote in the annual election." When election time came, he added, only 117 of the 330 members had met this requirement. And of the 117, only seventy-seven actually cast ballots.

His conclusion: "We are not so sure that, clinically speaking, this would be considered a healthy situation."

She's an Army Regular

A San José (Calif.) doctor, Lieut. Fae M. Adams, has quit the reserves but not the Army. She now holds the first regular commission ever granted to a woman physician.

'Publicize Tax Returns To Halt Fee Splits'

There's an easy solution to the fee-splitting problem, says the Milwaukee Journal: Open Federal income tax returns to public inspection. Many fee splitters could then be spotted, the paper explains, since the Bureau of Internal Revenue now permits surgeons in some states to deduct from their taxable income what they pay out to other physicians.

Moreover, it adds, there's ample precedent for a Federal open-tax-

for the treatment
of pertussis and other
respiratory infections -

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IN PERTUSSIS

"The use of Terramycin was considered successful in thirty-eight of forty-one pertussis patients"

"The most significant clinical change noted was the shortening of the whoop stage by 8.4 days as compared to the control group. The temperature was noted to drop rapidly in response to the drug, and there was a general lessening in the appearance of toxicosis fairly soon after the initiation of therapy"

The average period of hospitalization was about three days shorter than in the control group, and the total length of the disease showed a ten-day reduction."

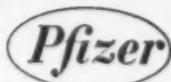
AND OTHER RESPIRATORY INFECTIONS

"Most respiratory infections responded promptly to Terramycin."²

" . . . an effective therapeutic agent in cases of respiratory infections due to: *D. pneumoniae*, *M. pyogenes* (*Staphylococcus*) var. *aureus*, *H. influenzae* and beta hemolytic streptococci."³ A "drug of choice in the treatment of atypical pneumonia in infants and children."

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1. Booher, C. E., et al.: *J. Pediat.* 38:111 (April) 1951.
2. Yow, E. M., et al.: *Am. Pract.* 2:689 (Aug.) 1951.
3. Potterfield, T. G., and Starkweather, G. A.: *J. Philadelphia Gen. Hosp.* 2:6 (Jan.) 1951.
4. Graves, F. B., and Ball, W. O.: *J. Pediat.* 39:155 (Aug.) 1951.

return law; some states already have such statutes. The Journal cites Wisconsin's law as one that has produced "no abuse" and "much good." Its conclusion: "There is no reason to suppose that opening Federal tax returns would not have the same beneficial results."

Doctor' Loses Practice

In New York's Harlem, Lee G. Williams had a thriving practice, partly as a result of a bright idea for attracting patients: He treated each new patient free on the first visit.

Grateful laymen gladly distributed his professional cards (which read: "Lee G. Williams, M.D., Physician").

Then one patient moved to another neighborhood, changed doctors, and listed Williams as his former physician. A check of medical directories showed no such M.D., and the new doctor got in touch with the county medical society.

Result: arrest for Williams, who was no doctor in spite of his thriving practice.

Hospital Is Scene of Quiz on Economics

Do too many physicians learn the economic side of the profession only after hanging out their shingles? District of Columbia medical leaders think so; to help local doctors get a head start on these problems, they've set up an experimental pro-

gram, aimed at teaching economics to young residents and internes.

The first session of the course was set for this month at Washington's Gallinger Municipal Hospital. There, experts in law, medical administration, and insurance planned to conduct a "Question Hour"—with all questions submitted in advance.

Young doctors are said to have reacted to the project enthusiastically.

Not Everyone Deplores The Magnuson Report

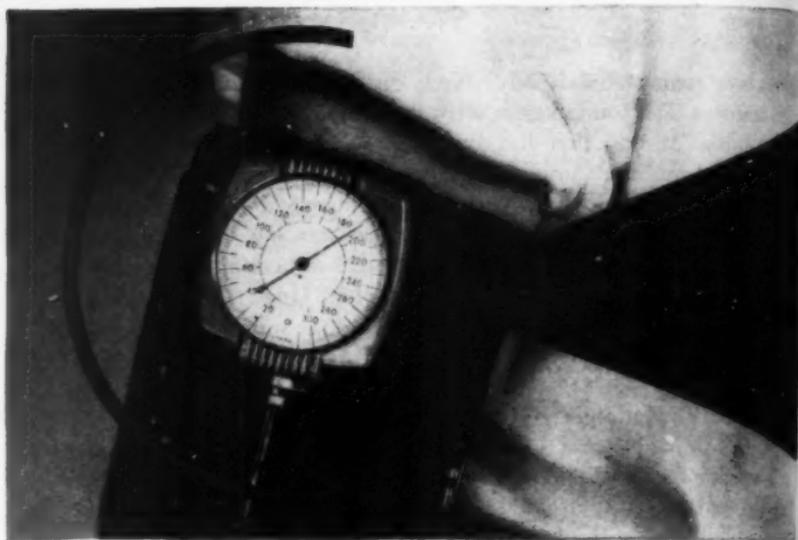
G.P. academy and New England Journal of Medicine praise it

Discussion of the Magnuson Commission's report continues—and not always along expected lines. There's plenty of criticism, of course. The A.M.A., for instance, charges that the commission seems to have only one answer to every health problem: "additional Federal funds." And the Association of American Physicians and Surgeons calls the commission's recommendations "definite steps to socialization through Government subsidy and inevitable controls."

But there's also a fair ration of praise for the commission and its report. For example:

¶ The American Academy of General Practice states that there's "singularly little in the completed report which organized medicine can tenably criticize."

¶ And the New England Journal of Medicine editorializes that the



to lower a hypertensive's blood pressure

It is desirable to

1. reduce blood pressure to near-normal or normal levels
2. alleviate hypertensive manifestations
3. improve patient's condition even if blood pressure is not markedly altered.

These objectives are now attainable with Methium—an "orally effective ganglionic blocking agent."¹ The clinically significant drop in blood pressure usually results in disappearance of subjective symptoms such as headache, dizziness, fatigue, palpitation.

Methium is indicated specifically in cases of severe hypertension unresponsive to the conventional therapy of bed rest and sedatives. Once lower blood pressure levels are reached and maintained, the

slowly increased Methium dosage can usually be stabilized and benefits sustained for prolonged periods.

Prior to treatment each hypertensive should be evaluated individually. Therapeutic response to Methium varies. It is a potent drug and should be used carefully. In the presence of complications such as impaired renal function, coronary artery disease and existing or threatened cerebral vascular accident, caution is particularly indicated. Complete instructions for prescribing Methium are available on request and should be consulted before using the drug.

Methium is supplied in both 125 mg. and 250 mg. scored tablets in bottles of 100 and 500.

1. Grimson, K. S., et al.: J.A.M.A. 149:215 (May 17) 1952.



WARNER-CILCOOTT
Laboratories NEW YORK

fault-finders tend to overlook the report's good points, just "as an unhappy diner, concerned only with the bones in a plate of fish, forgets that some excellent meat may also be present and may, indeed, constitute the chief virtue of the dish." Its considered judgment: "Many of these recommendations will surely turn out to be acceptable . . . There need be no question that all are sincere and honest."

Court Upsets Hospital Ban on Surgeon

In another hot legal battle over major surgery privileges, a 42-year-old New Jersey physician has won his case. Yet the court rejected Dr. William Jacobs' main contention: that his state license automatically entitled him to perform such surgery.

Why, then, did the court rule against the municipally run Irvington General Hospital? Because, according to the judge, the hospital hadn't lived up to its own rules: It hadn't issued written charges and held a formal hearing before denying major surgery privileges to Dr. Jacobs.

Although the court saw no reason to question a municipality's right to set standards for its hospital staff, it ruled that such standards "should be general and not arbitrary or discriminatory." And it found this evidence of arbitrary action in the Jacobs case: While the physician was on probation at the hospital, he had



William Jacobs
Cleared for major surgery

performed fifty operations without a fatality; yet the staff had termed him "inept."

Witch Doctors Cast Out Black Magic

You're not alone in your battle against quacks. Even witch doctors are now trying to cleanse their ranks of fringe practitioners.

In Capetown, South Africa, a witch doctors' association—membership 900—has announced a projected \$30,000 university, in which the teaching of black magic and the brewing of love potions will be forbidden. Says association president Lukas B. Somo: "Our objective is Government recognition of witch doctors as herbal practitioners."

Deploring charlatanism among



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A unique B-D molding process eliminates the grinding of syringe barrels previously needed to achieve required fit. Clear glass, unground barrels assure:

less friction: The microscopically smooth, unground surface of the clear glass barrel virtually eliminates friction between barrel and plunger.

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medicine men, Somo adds (firmly): "No student will be admitted to the school unless he or she can read and write."

Medical Grand Jury' Cuts Fee Complaints

Colorado patients make one-third fewer protests of this kind

A one-third reduction in complaints of overcharging—the leading cause of doctor-patient misunderstandings—has been credited to the Colorado State Medical Society's five-year-old "medical grand jury." This twelve-member board hears all charges against Colorado doctors, from lay or professional sources, of misconduct, breach of ethics, or fee abuses.

When the board began its work, three out of every four cases had to do with fees. But fees now figure in less than one out of every two cases, says the board's latest annual report.

Why the drop? Reportedly because one of the by-products of the board's hearings is a "continuous educational campaign within the profession."

As part of this campaign, the report offers doctors some tips for avoiding fee troubles. Among them:

The doctor should discuss medical care costs directly with his patient, instead of leaving them to an office assistant.

The patient should be told before treatment that the physician's

fee won't cover X-ray work, laboratory tests, or similar auxiliary services.

If it's apparent that Blue Shield or other insurance won't take care of the patient's total bill, this fact should be pointed out in advance.

When treatment proves ineffective, "a doctor might well become his own public relations officer and reconsider the original fee in view of the results obtained."

Just as important, emphasizes the report, is avoidance of the "appearance of overcharging." For instance: "To make a show of affluence is in poor taste. A salaried patient who has paid even a reasonable surgical fee cannot help but feel some ill will . . . to see his physician pictured in the newspaper covered with leis on his . . . Hawaiian holiday."

Hospital Drops Fight Against Doctors

Seven Poughkeepsie (N.Y.) doctors seem to have won their fight to belong to a birth control organization while serving on the staff of a Roman Catholic hospital. The issue was spotlighted more than a year ago, when St. Francis Hospital directed the doctors to make a choice: either quit the Dutchess County League for Planned Parenthood or resign from the hospital staff.

Four refused to give up the league; three complied, to protect the interests of patients then in the hospital. But at least one of those

to reduce tension or to induce sleep



CARBRITAL®

calms the restless...rests the sleepless

CARBRITAL is invaluable for reducing daytime tension or inducing prompt, refreshing sleep at night. It combines the hypnotic action of sodium pentobarbital, plus the milder hypnotic but more prolonged sedative effect of carbromal. With CARBRITAL, patients relax easily, fall asleep quickly, and awaken refreshed and alert.

CARBRITAL is useful in a wide variety of indications including insomnia, nervous tension, and preoperative or obstetrical preparation.

Each CARBRITAL KAPSEAL (Full-strength) contains:

Pentobarbital sodium	1/2 grain
Carbromal	1 grain
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Pentobarbital sodium	1/4 grain
Carbromal	1/2 grain

Each fluidounce of CARBRITAL ELIXIR contains:

Pentobarbital sodium	1 grain
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CARBRITAL KAPSEALS, full or half-strength, may be taken by adults in doses of one or more, on schedules determined by the physician. Children may be given $\frac{1}{2}$ to 1 teaspoonful of CARBRITAL ELIXIR; adults 1 to 2 teaspoonsful or more as required.



Parke, Davis & Company

who quit the organization has since rejoined; and all seven men apparently still retain St. Francis staff privileges. A possible reason for the hospital's neglecting to carry out its threat: a growing danger of mass withdrawals from the staff if St. Francis administrators remained intractable.

Blood Bank Robbed

Jackson (Miss.) police have arrested a pretty, blond X-ray technician, Helen Hood. The charge: She allegedly embezzled money from a bank—the Baptist Hospital's blood bank.

According to the police, Miss Hood issued hundreds of \$25 blood contribution certificates to men friends for "phantom" blood sales. After the boys cashed in the certificates, they gave her \$20, kept \$5 for themselves. Her approximate total take: \$10,000.

And what did she do with all that money? She was using it, says Miss Hood, to pay her way through medical school.

G.P.'s Can Treat Most Mental Patients?

It's high time to remove psychiatry from "the realm of the fiction writer and put it back into medicine where it belongs," says Psychiatrist William K. Keller of Louisville, Ky. He maintains that most emotionally disturbed patients "can and should be treated by the general practitioner."



William K. Keller
Psychiatric care your job?

Such patients, he adds, aren't usually acute cases. Rather, they belong to "that frustrating group who can't produce organic disability to account for their complaint pattern"—the neurotics who "constitute about 50 per cent" of the G.P.'s office callers.

Some of these individuals are, of course, in need of specific psychiatric help, admits Keller. But most of them suffer from such common ailments as "tensions, pressures, worries, anxieties." And all they want, he says, is just what the G.P. can give them, namely: a sympathetic ear, plus friendly advice and reassurance.

When you *do* refer a patient to a psychiatrist, warns the Louisville specialist, be careful how you go about it. You'll make a great mis-

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This professional refillable, spray-type dispenser makes *Bactine* at home on your treatment table—ready for its many uses in antisepsis, cleansing and deodorizing. You'll find *Bactine* handier than ever in this handsome green dispenser that is yours for the asking.

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in this handy new dispenser*

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Hand disinfection	Antiseptis plus cleansing action	Minor surgery—cuts, abrasions, burns
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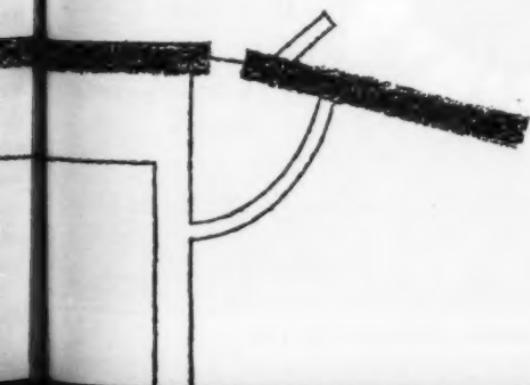
Write today for your *Bactine* professional dispenser. It's yours for the asking.

Bactine:

1-gallon, 1-pint, and 6-ounce bottles. From your regular supplier, or we will assist you in ordering.

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NEWS

take, he says, "to simply tell the patient that you're referring him to Dr. So-and-So for a check-up and then have him . . . upset when he finds himself in the hands of a psychiatrist."

Urge Payments Now for Old-Age Health Care

What can voluntary health insurance do to provide coverage for our senior citizens—who need more medical care as they grow less able to pay for it? One answer might be to persuade subscribers to pass up small claims during their productive years so that the amounts thus saved could be used for premium prepayments after retirement. An alterna-

tive arrangement: Let subscribers pay an extra premium in early years to cover benefits during old age.

Whatever the method, says the A.M.A., people must somehow be encouraged to pay for lifelong medical care when they're best able to do so. Unless this is done, it warns, public funds will be needed to fill the gap.

A Developing Practice

There's a trend toward realism in Hollywood, says Dr. Robert Franklin, a movieland plastic surgeon. As evidence, he proudly points to the rounded bosoms of twenty-five screen beauties. Even their best friends wouldn't guess, he explains.

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infections
in 100 mg.
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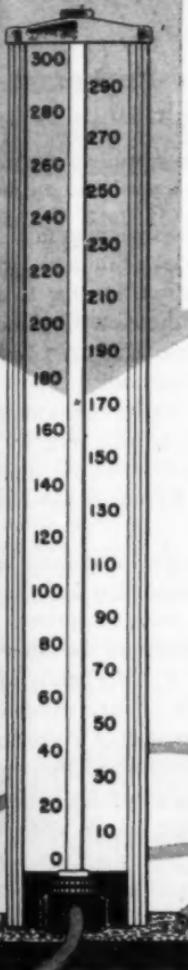
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A synergistic hypo-
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plus effective
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Each **TURASED** tablet contains:

Pentoobarbital Sodium $\frac{1}{4}$ gr. (16.2 mg.)
(Warning: May be habit-forming)
Potassium Thiocyanate $\frac{3}{4}$ gr. (48.7 mg.)
Sodium Nitrite $\frac{1}{2}$ gr. (32.5 mg.)
Rutin 10 mg.

SUPPLIED: Bottles of 100 and 500 coated
(yellow) tablets.

1. Parsonnet, A. E., et al.: J. M. Soc. New Jersey
47:504, 1950.

THE
L. L. PATCH CO.
STONEHAM,
MASSACHUSETTS

TURASED PATCH

NUBILIC

In Spastic Colitis

In gastrointestinal dysfunctions such as spastic colitis, which is often associated with biliary stasis, the hydrocholeretic—antispasmodic—sedative action of NUBILIC is of benefit. The pure dehydrocholic acid tends to soften the stool without presenting an immediate possibility of a diarrhea.

Each NUBILIC tablet contains: Dehydrocholic acid..025 Gm. (3½ gr.) Phenobarbital..8 mg. (½ gr.) Belladonna..8 mg. (½ gr.)

Average Dose: 1 to 2 tablets three times daily, after meals.

Supplied: Bottles of 25, 50 and 100.

NUMOTIZINE, Inc.
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FOR INFECTIOUS **DANDRUFF**

**ITCHY, IRRITATED
SCALP CONDITIONS
RECOMMEND**

HERBEX PINK OINTMENT

ACTIVE INGREDIENTS:

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SULPHUR, GLYCERINE,**

Petrolatum Base

NO PRESCRIPTION REQUIRED

Sample on Request

PARKER HERBEX CORP.
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NEWS

that they owe their curves to surgery.

Franklyn's method consists of inserting under the skin, and in the proper place, a plastic false that's spongelike and fleshy to the touch. Only he and the patient know the real truth, he says. Franklyn is married to actress Vanessa Brown.

Follow-Up Found Faulty In Multiple Screening

Boston study indicates many G.P.'s don't act on findings

Multiple screening may sound like a good idea. But how good is it in practice? According to a recent report in the New England Journal of Medicine there are two big dangers in the method:

1. Patients are sometimes given "a sense of false security" by a clinic examination whose limitations and results they may not clearly understand;

2. Communications between the screening center and the family doctor are often imperfect.

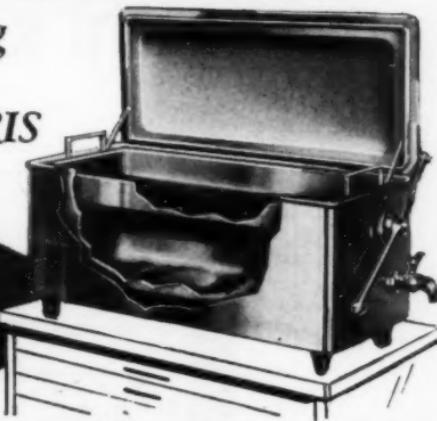
To illustrate the latter point, Drs. Robert P. McCombs and John J. Finn Jr.—both members of the teaching staff of Tufts College Medical School—cite the experience of Boston's Pratt Diagnostic Clinic in examining nearly 600 employees of a large insurance company.

The patients filled out elaborate self-screening questionnaires. They underwent an assortment of tests

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A Table shewing the Hour of the Day, by any Stick, or Walking Stick, divided into Ten parts.

Before Noon.	11	10	9	8	7	6					
After Noon.	12	1	2	3	4	5					
I	11	12	1	5b	6	7b	9c	1b	19a	30b	57
I	12	13	2	5b	6	7b	10	11b	19b	30	59
S	21	2	3	5c	6b	7c	10	14	20a	32	65
M	11	13	1	6a	6c	8a	10c	14c	21b	35	71
S	30	23	-	7	7b	9	11b	15	23	40	10
A	20	2	3	7c	8a	10	12c	17b	26b	48	19
A	9	13	A	8c	9a	11	14	19b	30a	62a	
S	30	23	-	10	10b	12a	15	22a	30b	62a	
M	20	2	3	11a	12	14	18	26	46	82a	
S	10	13	S	13	13c	16	21	31a	62c		
S	28	23	-	15	16	18c	24c	39	97a		
E	18	3	2	17b	18b	22	29c	51	210		
O	8	13	O	20b	21c	26	36	70			
S	29	23	-	24	25b	31	46	110			
I	19	2	3	28	29c	37	59	208			
N	9	11	N	32	34b	44	76	829			
D	30	21	-	36	39	51	97				
D	21	1	3	29	42b	56b	117				
D	11	13	D	42	43c	59	126				

*Reproduced from "The Young Man's Companion (or Arithmetick and other Arts Made Easie)," printed for S. Clark in George Yard, Lombard Street, 1699.

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Medical Economics, Inc.,
Rutherford, N. J.

~~en~~emory needs a friend . . .

If a 17th century physician could remember
the facts in the table at left*, he needed only his
walking stick (and a little sunshine) to tell
him the time of day.

But times have changed.

And just as the watch is today indispensable for
telling time, PHYSICIANS' DESK REFERENCE
is the accepted source of information concerning the
growing variety of pharmaceutical specialties
available to the medical practitioner in 1953.

PDR

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NEWS

and each was given a fifteen minute examination by a physician.

All findings were reviewed by an internist. Family doctors were instructed in the necessary follow-up. And in forty-two cases, problems were labeled "urgent"—which meant that the patients needed immediate medical attention.

Yet, say McCombs and Finn, in fifteen of these cases the recommendations weren't carried out. Why? Either because the patient refused to act, or because the family doctor disagreed with the findings and failed to act, too. So "an appreciable number of patients apparently did not receive maximum benefits from this study."

Conclude Drs. McCombs and Finn: "Continued education of patients and physicians in the function of mass screening clinics is essential."

Two Days Too Many?

Latest promotional twist of the chiropractors: They're worming their way into industrial health posts by reminding management that one in every four factory injuries affects the back—which they regard as their territory. Chief selling point: They claim that their methods cut medical care costs in half and reduce lost time by up to 75 per cent.

And how do chiropractors prepare themselves for industrial posts?

Says practitioner George Huff, director of industrial relations for the

In Whooping Cough

Treatment

Response
is Dramatic

with
Hyland
Pertussis
Immune
Serum
(human)

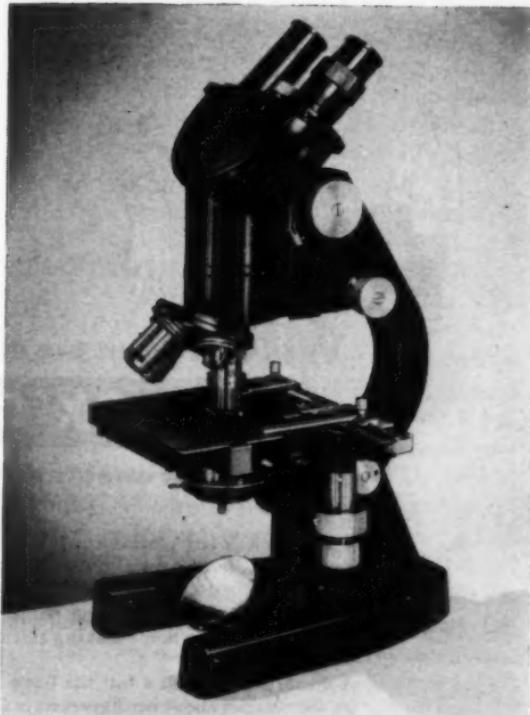
Reduction of paroxysms is most marked when the serum is administered early in the course of the disease. Supplied 20cc. dried irradiated serum, with diluent.

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your
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and sweetened gelatine desserts

Turn about is fair play, doctor! We believe the little lady who generally *asks* the questions can *answer* this one. Why? Because she is one of our best customers and interested correspondents, giving us useful ideas and asking for our recipes and dietaries. In this way, she keeps up with the home-making side of your patients—your practice.

A doctor's wife leads a full life but a good life. From what she tells us, she worries about her figure, stays away from excess sweets, knows the importance of adequate protein intake—just as you advise your patients.

But she knows something else that's important! She knows factory-flavored gelatine desserts cannot claim a low caloric content because they are made with 85 percent sugar! Mighty different from KNOX Gelatine (U.S.P.)—all protein and *no sugar*.

Supplementary protein is always an important dietary recommendation. KNOX furnishes 7 out of the 8 amino acids regarded *essential* and most of the 23 tissue-building amino acids. And with KNOX, it's so easy to make *sugar-free* desserts if you want to prescribe them.

Which is why, doctor, we're sure your wife will go along with the idea of specifying KNOX to give the patient *exactly* what you order.



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4-envelope family size and
32-envelope economy size packages.

KNOX GELATINE U.S.P.

ALL PROTEIN

NO SUGAR

International Chiropractors Association: "We are offering . . . a two-day special training course."

Newcomers to Society Get Royal Welcome

Two or three times a year, the Indianapolis Medical Society gives a dinner party for the sole purpose of welcoming its new members. At these dinners, the new men (there were sixty of them last year) are introduced to most of their 900 local colleagues. In addition, they're given straight-from-the-shoulder briefings on such everyday practice problems as referrals, fees, emergency coverage, and ethics.

Most important of all, perhaps, each neophyte is assigned a "senior

sponsor"—usually someone he knows, or else an older member of the society—to act as his adviser for a year or two. In their presentation speeches, the sponsors tell the dinner audience about the educational and professional backgrounds of their respective charges. The dinners, for both sponsors and new men, are on the house.

The program was initiated in 1951 by Dr. Harold Ochsner, now president of the society; and it has apparently been an enormous success. Says Dr. Lester D. Bibler, chairman of the society's public relations committee:

"The dinner meeting establishes a better liaison between old and new members of the society; and the sponsor system makes the new mem-



Lester D. Bibler



Harold Ochsner

Their society's dinner program helps new members

NEWS

Of all milk replacements - only Mall-Soy® points to a long and imposing array of clinical reports.

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Schering

A dividend of twenty-five cents (\$0.25) per share has been declared payable March 5 to stockholders of record February 9, 1953.

The transfer records will not close. Bankers Trust Company of New York will mail the checks.

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Time wasted hunting for vital records is time and money lost forever! Modern, economical INFO-DEX Charts provide:

- Your present records easily incorporated no re-writing of old histories.
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Send for samples & catalog.

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Free samples and catalog on
charts and filing cabinets. M.E.4

G. P.

Specialty

Dr. _____

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City _____

Zone _____ State _____

ber feel he has someone who is personally interested in him—someone to whom he can go for advice on various problems connected with his profession . . . Most of the members say they wish they'd had such an introductory course when they first joined the society."

Guard Patient's Purse, G.P.'s Are Advised

Iowa A.A.G.P. tells how to be surgical fee gouging

It's up to the G.P. to serve as "guardian of his patient's pocketbook as well as his life." So if the bill for a surgical procedure seems exorbitant, "someone is much at fault and the family doctor had better take things in hand," says the Iowa Academy of General Practice, commenting on the great fee-splitting debate now going on in that state.

Here are four ways in which the general practitioner can live up to this responsibility, says the academy:

1. He can make a point of knowing "what the average fee for a given procedure should be. To control abuses of overcharging, [he] should be actively interested in seeing that an average fee schedule be set up and published for his county."

2. Whenever possible, he should discuss the financial problems of illness and accident with patients before referring them to a surgeon or other physician.

[MORE]

KHELLOYD

TRADEMARK

"BENEFICIAL"^{*} IN ANGINA

"... is a *beneficial drug* in the treatment of *angina pectoris*, and, when used in therapeutic amounts, eliminates toxic effects that may well be produced by the impurities present in the crude preparations."*

Khelloyd Dosage—Since Khelloyd is a potent therapeutic weapon, the dosage must be individualized to the patient. Recommended initial dosage—1 tablet daily for one week—increased to 2 tablets daily, if necessary, as average maintenance. Khelloyd is also proving highly effective in relieving asthmatic attacks.

Available—Khelloyd (white) scored 50 mg. pure khellin tablet. Khelloyd W/P (yellow) 50 mg. pure khellin with 1/4 gr. phenobarbital (where associated nervous tension is present). Both products are packaged in bottles of 50 and 250 tablets.

Publications on Khelloyd

Nishizaki, L.A.; Rudy, W.B., and Gilbert, N.C.: Use of Crystalline Visammin (Khelloyd) in Treatment of Angina Pectoris, *Med. Lit. Extr.*, J.A.M.A. 150:720 (Oct. 18) 1952, from Circulation 5:801-960 (June) 1952.
Scott, R.C., and Seiwert, V.J.: The Treatment of Angina Pectoris with Pure Crystalline Khellin, *Ann. Int. M.* 36:1190 (May) 1952.
Cox, J.J.; Kimane, R.W.; Koona, R.A., and Clark, T.E.: The Treatment of Angina Pectoris with Khellin, *Ann. Int. M.* 38:23-27 (Jan.) 1953.

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LLOYD BROTHERS, INC., CINCINNATI 3, OHIO



PENALEV Tablets dissolve readily in milk formulas and fruit juices without appreciably altering their taste.

In treatment of the more commonly encountered systemic infections . . .

Penalev® TABLETS

SOLUBLE TABLETS CRYSTALLINE POTASSIUM PENICILLIN



Following oral administration of penicillin, "sensitivity reactions of all types are much less common... as compared with parenteral therapy."

are at least as effective as the considerably more expensive newer antibiotics . . . and are *very much less toxic.*^{1,2}

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*50,000, 100,000 AND 250,000 UNITS, IN PACKAGES OF 12 AND 100 TABLETS



Keefer³ has stated that in most cases, "therapeutic results that follow oral therapy are comparable in every way to those following parenteral therapy."

1. Brit. M.J. 2:1361, 1951
2. Brit. M.J. 2:1345, 1951
3. Am. J. Med. 3:216, 1952
4. J.A.M.A. 147:207, 1951

NEWS

3. "Armed with the above information," he should frankly tell the second doctor what he thinks the charges should be. And, adds the academy, "you had better look for someone else," if the other man refuses "to go along with you."

4. He can remember that he isn't exhibiting weakness by being human.

Amplifying this fourth point, the academy states: "Whenever doctors lack honesty and fairness in their dealings with patients or fail to show compassion for the sufferings of humankind," they forfeit esteem and degrade the profession.

Calls Interne Matching Plan a Success

How is the plan to match hospitals and internes working out? There's varying opinion on this around the country; but at least one state medical society—Indiana's—regards the idea as a success.

By attempting "to fill all the best internships with the best applicants," the plan saves time and frustration, says an editorial in the Journal of the Indiana State Medical Association. It cites these national figures:

Of 5,681 students who participated last year, 84 per cent wound up as internes in hospitals of their first choice. And the 795 participating hospitals fared almost as well: They took on 74 per cent of the students they most wanted." [MORE→]

What's in a Trade-mark?



For your protection and ours, the 'Q-Tips' trade-mark is jealously guarded. It symbolizes the one and only *original* cotton swab... trusted for over a quarter of a century... used by more hospitals, doctors and nurses than any other brand.

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NEWS

Of course, says the Indiana editorial, there are still nearly twice as many internships as there are applicants; the matching plan doesn't even try to solve this problem. But at least, it adds, the hospitals' old "scramble" for internes has been reduced appreciably.

Grave Situation?

What's in a name? Not a thing, apparently—at least in Arizona, which boasts a lively town called Tombstone. Name of the local hospital: Tombstone General, naturally.

G.P. Is Called Key Man In Preventive Medicine

Public health men hear offer aid from family doctor

The G.P. is the key man in preventive medicine, the American Public Health Association was told recently by the president of the Michigan

Anecdotes

¶ MEDICAL ECONOMICS will pay \$10-\$25 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

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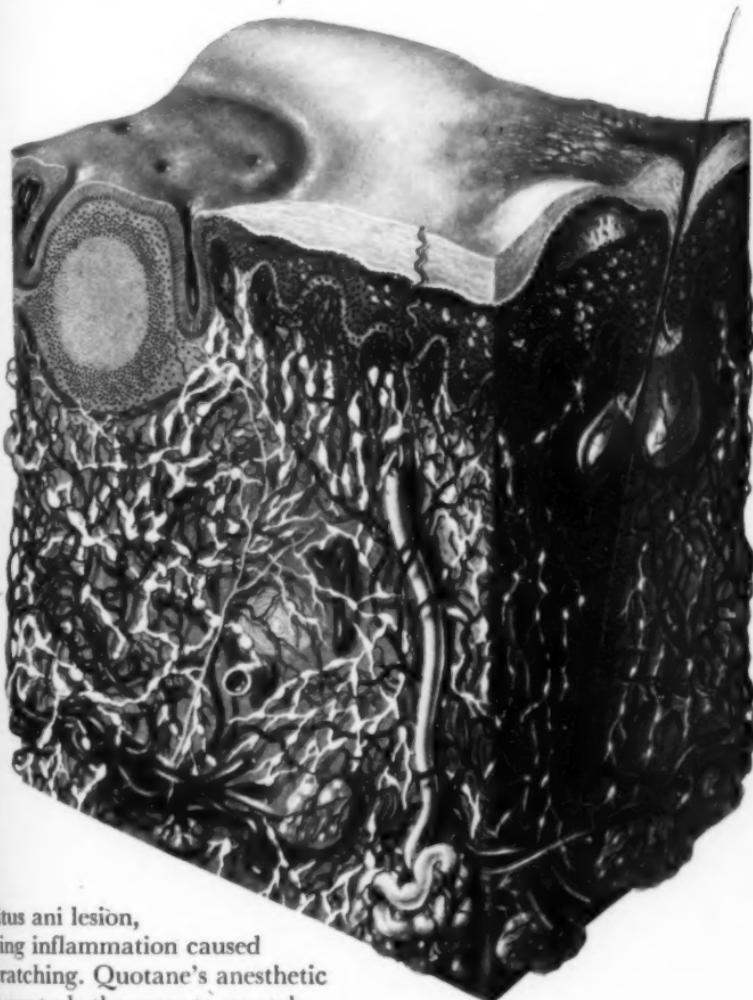
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Pruritus ani lesion,
showing inflammation caused
by scratching. Quotane's anesthetic
effect controls the urge to scratch.

Quotane* Ointment Also available: 'Quotane' Lotion

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How to produce effective bacteriostasis in sore throat and post-nasal drip

INSTILLED INTRANASALLY, 'Paredrine'-Sulfathiazole Suspension covers the nasopharynx and pharynx; coats infected mucosa with a soothing, bacteriostatic blanket. It is not quickly washed away, but clings to the throat for hours—insuring prolonged bacteriostasis. The Suspension is particularly effective in sore throat when instilled on retiring. Frequently, it produces bacteriostasis (and analgesia) all night long.



Pharynx is inflamed *before* administration
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Vasoconstriction in minutes . . . bacteriostasis for hours.

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NEWS

Health Council. But, cautioned Dr. J. S. DeTar—himself a family doctor—don't try to *push* the G.P. into the field; the family doctor is "still quite an individualist," and he "must be educated and led" into cooperating with health officers.

Addressing an A.P.H.A. meeting in Cleveland, DeTar drew on personal experience to illustrate his point. When his county health director stated four years ago that immunizations were far below the desired level, DeTar was skeptical enough to check 100 babies that he himself had delivered. His findings: Only forty-seven of them had been immunized in their first year, despite instructions to the mothers.

Impressed by this and similar sur-

veys, DeTar's county medical society joined with the health department to establish free immunization clinics. When a subsequent count showed that 78 per cent of all children had been immunized, the health director thought the free clinics could be dropped. But the doctors disagreed, said DeTar; they insisted the clinics be made permanent.

Here, he added, was a prime example of how education can change the attitude of G.P.'s from mere "toleration of public health efforts to enthusiastic cooperation."

But can the average family doctor go a step further and become an adequate part-time health director? No, says DeTar. "As a G.P. in an average town, with an average prac-

THE BIRTCHER



Blendtome PORTABLE ELECTROSURGICAL UNIT

GAINING WIDESPREAD ACCEPTANCE IN OFFICE AND CLINIC

THE BIRTCHER BLENDTOME provides your office or clinic ample facilities for all but the strictly major cases. Cutting, coagulation, desiccation, fulguration and bi-active coagulation are provided by the Blendtome.

The Blendtome offers you effective control of bleeding, reduces risk of infection.

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Wet dressings are highly recommended for their marked freedom from irritation and their beneficial effect in a wide variety of dermatoses. Now, PROPHYLLIN provides sodium propionate and water-soluble chlorophyll to increase the safety and efficacy of this preferred mode of therapy.

- more physiologic
- nonastringent, nontoxic
- nonirritating, nonsensitizing
- relieves itching and irritation
- mildly bacteriostatic and fungistatic

...as condition improves
the benefits of PROPHYLLIN Wet Dressing can be maintained by prescribing
PROPHYLLIN OINTMENT

PROPHYLLIN Powder, for preparation of wet dressings, in cartons of 12 packets. Each packet contains 2.3 gm. powder, sufficient to prepare 8 ounces of solution containing 1 per cent sodium propionate and 0.0025 per cent water-soluble chlorophyll. Also

4-oz. and 16-oz. jars. Note: When dissolved, PROPHYLLIN is free of propionate odor.

PROPHYLLIN Ointment, 1½-oz. and 4-oz. tubes. PROPHYLLIN Ointment contains 5 per cent sodium propionate and 0.0125 per cent water-soluble chlorophyll.



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For INTERNAL IODINE THERAPY
Colorless — Effective — Palatable
Since 1878 we have specialized in
making Hyodin the finest preparation
for internal iodine medication.
Dosage—1 to 3 tsp. in $\frac{1}{2}$ glass water—
 $\frac{1}{2}$ hour before meals. Available—4 and 8 oz.
bottles. Samples and literature on request.
Firm of R. W. GARDNER Orange, N.J.
Est. 1878

NEWS

tice, I am frank to confess that I couldn't do the work of a public health officer, for two reasons: I don't have the time, and I don't have the training. It will be a happy day for the health of the American people when every county is protected by an organized public health department."

Organizing and Operating A Group Practice Or Partnership

Now available, as the result of numerous requests from physicians, is a portfolio of reprints on group practice and partnerships. It contains about a dozen of the most requested articles on this subject published in MEDICAL ECONOMICS. The portfolio is book size, with a durable, leatherette cover and with the title stamped in gold. Prepaid price \$2.

4-53

Medical Economics, Inc. Rutherford, N.J.

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Street

City State

Who's Crazy Now?

In Philadelphia, confessed cop killer Theodore Elliott has asked the Pennsylvania Supreme Court to set aside his death sentence. Although he was declared sane at his trial by a municipal court psychiatrist, the doctor himself was found mentally incompetent six weeks later, in a court action brought by his own wife.

'Private Health Plans Too Expensive'

Labor writer cites figures to prove his point

The American Federation of Labor is still pushing for a national health insurance program; but now it has a new theme:

"The voluntary way is the expensive way," says A.F.L. News-Reporter columnist Lane Kirkland. And he offers these 1951 statistics as evidence:

¶ "Those wonderful voluntary plans, which are alleged to encompass more than half the population,"

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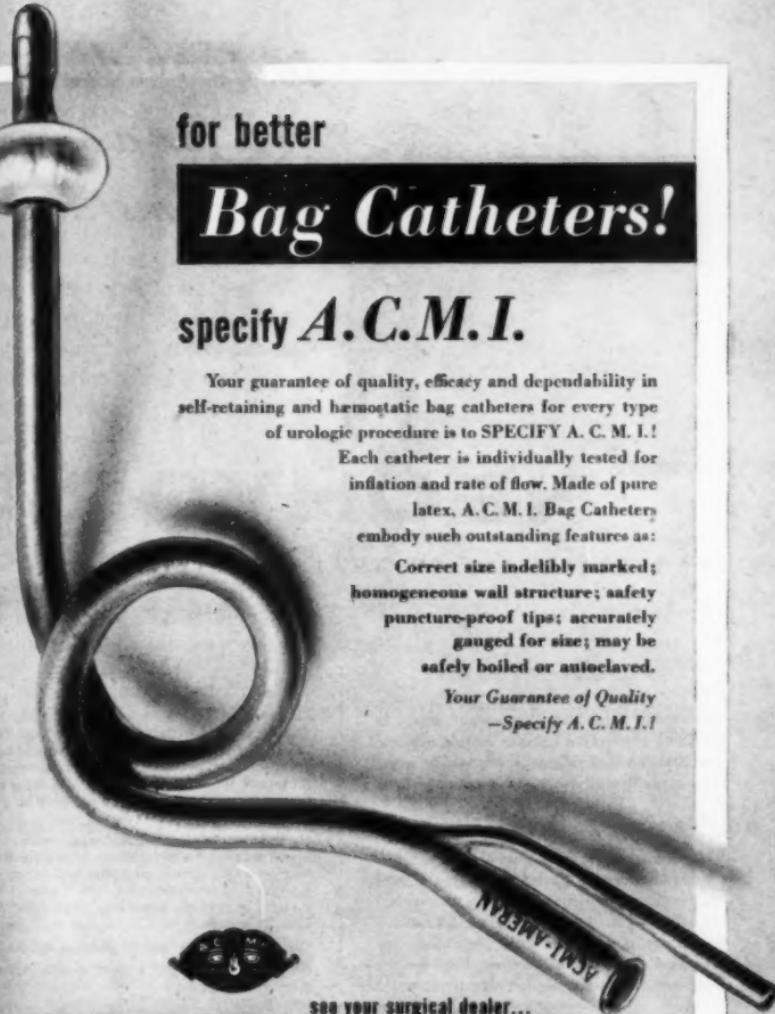
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paid for only 15 per cent of the nation's \$8.8 billion medical bill.

The public paid out \$2.4 billion in premiums to private health insurance agencies and got back only \$1.8 billion in benefits—"or about 75 cents on the dollar."

So it's a "myth that the economic problems of the sick and disabled are . . . being solved" by voluntary plans, claims Kirkland. And he calls this "myth" a "major obstacle" in the path of effective national health insurance legislation.

As chief myth-makers, he singles out the insurance industry and the political pitchmen of the A.M.A." He insists that they've inflated "the modest virtues of private health insurance plans into one of the biggest propaganda balloons afloat today."

Are Mass Chest X-Rays Worth the Cost?

Last fall, the Worcester (Mass.) District Medical Society made a chest X-ray survey of 154,000 persons. Now that the returns are in and the statistics compiled, Worcester doctors are wondering whether the results were worth the cost.

Certainly, the number of new TB cases discovered didn't justify the expense, says Dr. Nicholas S. Scarcello, chairman of the society's executive medical committee. And since the survey "has not proven anything we did not already know," he maintains that the money might better have been spent "in caring



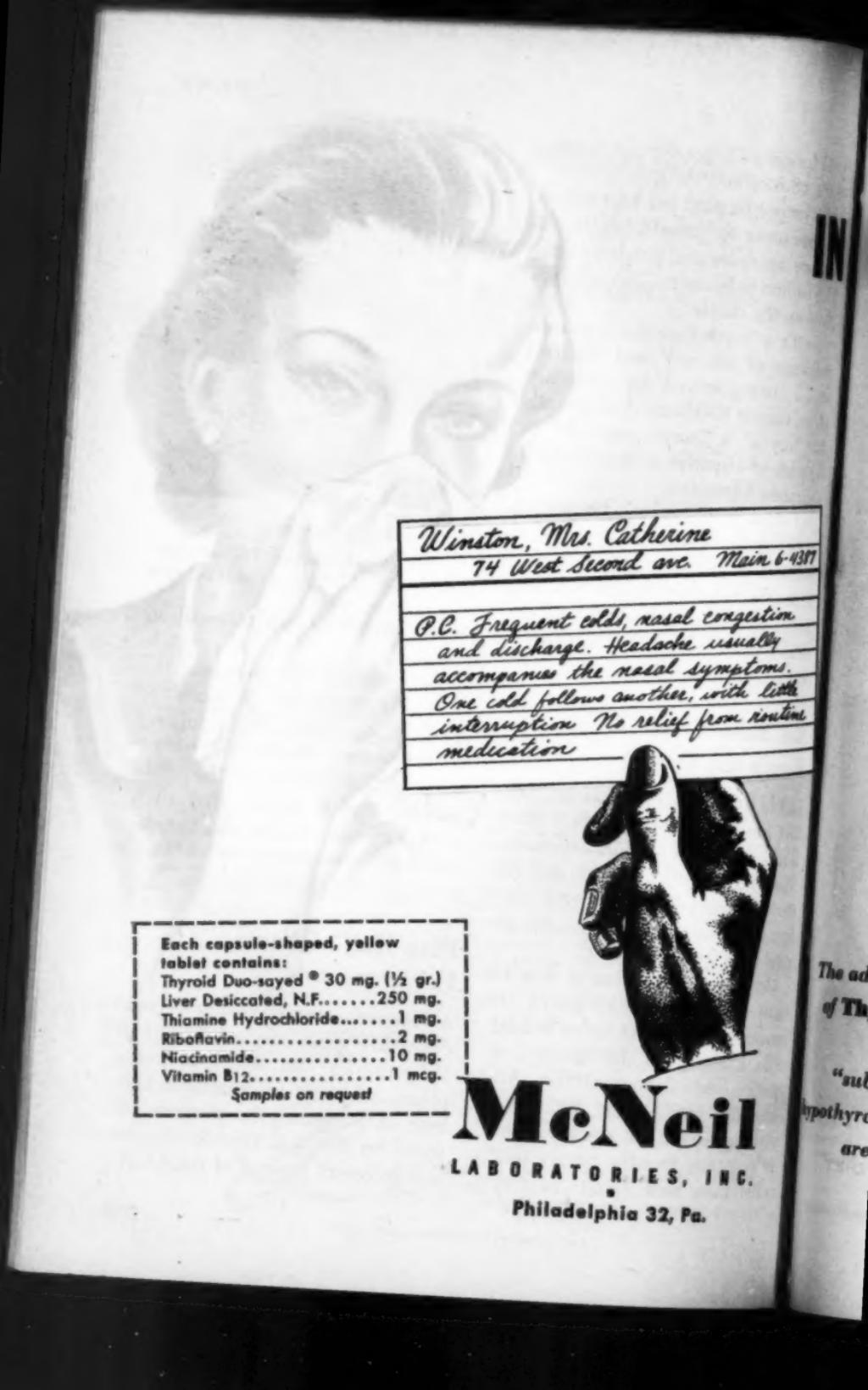
Nicholas S. Scarcello
Questions value of TB surveys

for the already known tuberculosis cases."

As a result of its experience, the Worcester committee questions the value "of continuing these surveys in other areas." They're all right, it points out, "if statistics are the prime motive." But it doubts that such surveys can do a better job of eradicating TB than that done by "local voluntary and health agencies."

Plan Hall of Fame For Surgeons

A Surgeons' Hall of Fame, to commemorate great surgical figures of all countries and times, is being planned by the International College of Surgeons. Its purpose, as stated by Dr. Max Thorek, founder and secretary general of the I.C.S.,



Winston, Mrs. Catherine

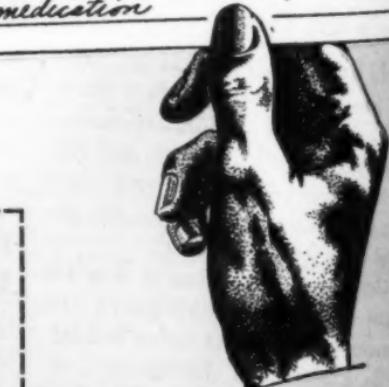
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"Subclinical Hypothyroidism"

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Proetz^(1,2) describes his experience with 130 patients with interminable colds, in whom diagnosis of hypothyroidism was reasonably certain. Confusing complications did not exist and response to thyroid extract therapy was demonstrable.

In this group the nasal cavity did not respond to conventional therapy, but improvement after treatment with thyroid was striking. Symptoms recurred when thyroid therapy was withdrawn.

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3. The necessary adjunct in thyroid therapy—the anti-thyrotoxic factor in liver—is included in Thyrobex.

1. Proetz, A. W.: Further Observations of the Effects of Thyroid Insufficiency on the Nasal Mucosa. *Laryng.* 60:627 (July) 1950.

2. Proetz, A. W.: The Thyroid and the Nose. *Ann. Otol., Rhin. & Laryng.* 56:328 (June) 1947.

3. Robertson, J. D. and Kirkpatrick, H. F. W.: *Brit. M. J.* 1:624 (March 22) 1952.

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is "to foster international friendship among surgeons and, through them, among the peoples they serve."

In an implied dig at its rival society, the American College of Surgeons, the I.C.S. points out that it's signal "equipped" to honor surgeons the world over. Why? Because "nothing in our charter . . . would confine access to surgeons of any one country."

With this in mind, the seventy-one I.C.S. sections around the world have been asked to submit nominations of surgeons who have contributed notably to the advance of medicine. Busts of all such men as are approved by an international electoral college will be placed in the Hall of Fame, together with bronze

plaques stating their achievements.

According to present plans, the memorial will occupy a building adjoining I.C.S. headquarters on Chicago's Lake Shore Drive.

Reed-Keogh Prospects Look Good, Says M.D.

What provisions is Congress likely to make for doctors' retirement programs? Social Security coverage as an initial and partial step is a possibility, according to some observers. Another is the so-called Reed-Keogh retirement pension bill (or, rather, bills).

But the chances for Social Security are slim, says Dr. William H. Lewis Jr., writing in New York

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NEWS

Medicine. Chief reason: Most physicians don't want it, since it's "inadequate for professional men."

More attractive, according to Lewis, are the Reed-Keogh bills, which would allow income tax deductions for income set aside in a retirement fund. The bills were introduced last year but were bogged down in committee. Now, says Lewis, the Republican-controlled Congress is likely to give them "more favorable consideration."

But he warns that doctors can't afford to sit back and wait for Congress to act. "If [physicians] consider the program of sufficient importance . . . and the benefits for the individual self-employed of proper value to themselves and their de-

pends, they should individually and collectively express support for the passage of its essential features."

Deery British Doctors' 'Mystery Mongering'

Doctors who keep hospitalized patients in the dark about their progress have been singled out for criticism. "Mystery mongering" is the Manchester Guardian's phrase for this silent treatment; and the well-known British newspaper maintains that "it can hardly fail to impede [a patient's] recovery."

The patient is usually accustomed to being treated "as a rational and responsible" person by his family doctor, says the Guardian. But "once

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NEWS

confined to hospital," it adds, such a patient is baffled by "the apparently ingrained reluctance of even the kindest hospital officers to tell him anything—especially about the nature and probable course of his illness."

Commenting on a Central Health Services Council report of hospital "shortcomings," the British paper concludes: "Nothing is more calculated to dishearten a patient, to undermine his confidence in his treatment, and to keep him seething with impotent fury than to be fobbed off with empty reassurances and soothing lies when he wants to know and to cooperate."

**Rural Doctor Program
Meets Opposition**

*Texas M.D.'s question value of
state aid for students*

What's the best way to get more young doctors into rural practice? The voters of Texas have decided—by a narrow margin—that one answer is subsidization of a selected number of medical students. Accordingly, they've adopted a constitutional amendment authorizing state aid for students who agree to practice for a certain time in country areas.

But that's only part of the story. Now it's up to the state legislature to create a fund to provide grants and a board to administer them. And this may be more easily said than

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NEWS

done, according to qualified observers. Here are some reasons why:

¶ A number of legislators deny that the measure's sole purpose is to attract more doctors to rural areas. They regard the amendment as a step toward socialized medicine, and they intend to fight it on that basis.

¶ Some law-makers doubt that a doctor could be legally compelled to practice where he didn't want to (even after he'd agreed to take up rural practice in return for state educational aid).

¶ Texas physicians in general aren't convinced that there still is a country doctor problem. Existing programs sponsored by the Texas Medical Association are, some insist,

already drawing large numbers of M.D.'s into rural areas.

What are these programs? One is a physician-redistribution plan; it found places for sixty M.D.'s last year—mostly in rural areas. And right now, the association maintains, there are a number of other doctors looking for new spots.

In addition, the association runs a preceptorship system that gives neophytes a taste of rural practice. Under the plan, junior—and occasionally senior—students spend three months learning the ropes at the side of country G.P.'s

These two plans, say many Texans, aim at the real problem: not the supply, but the *distribution* of physicians.

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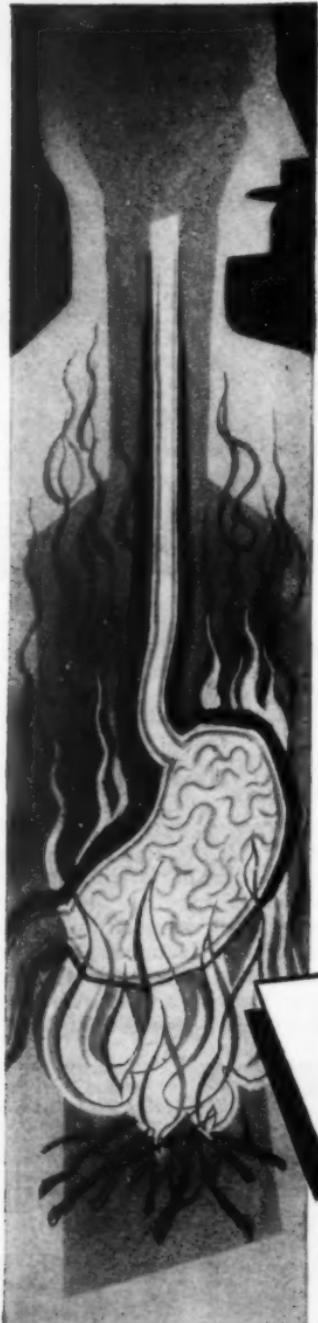
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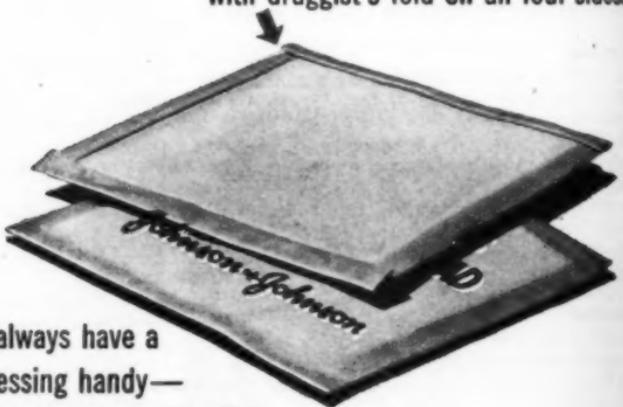
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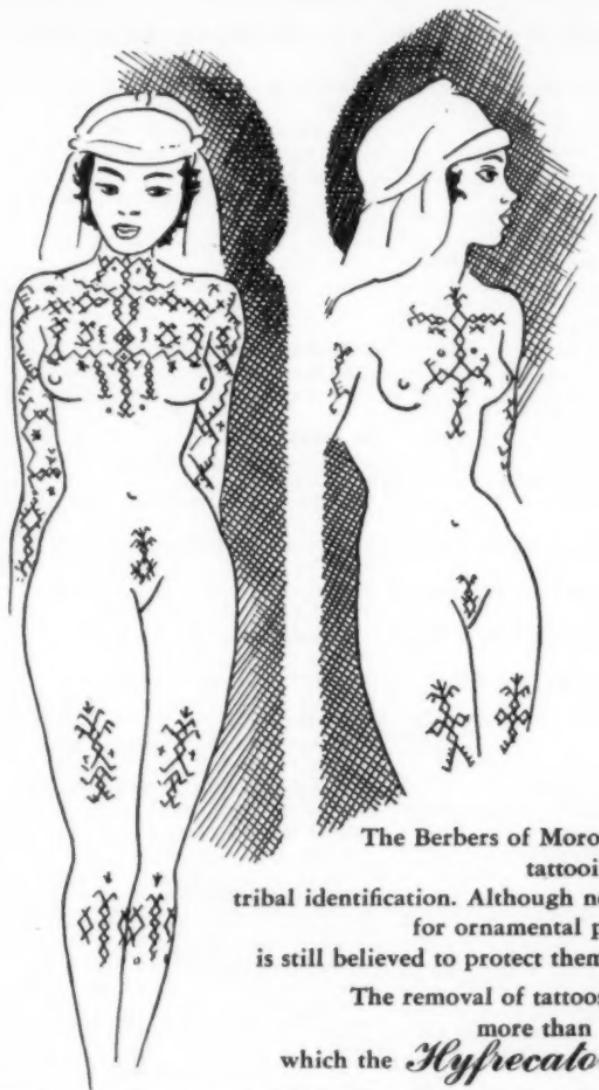
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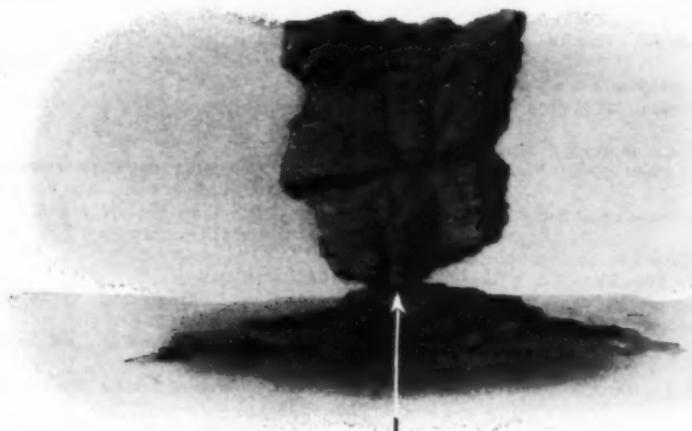
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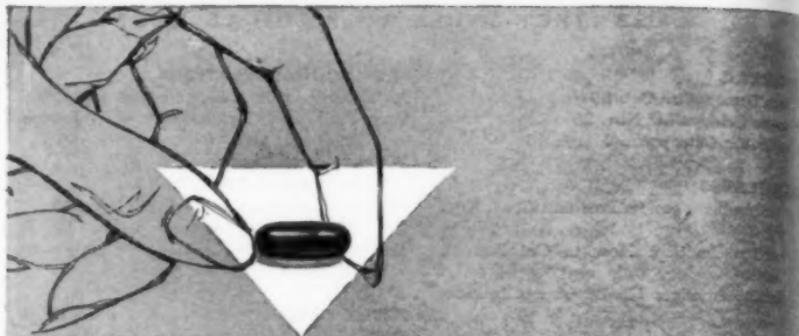
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Any Questions?

The letter came from a surgeon in Philadelphia. "Our thoracic clinic," he wrote, "needs some data on fees for major surgical procedures. We're thinking of changing our basis for setting such fees."

"Ten per cent of the patient's income has been an accepted basis. But with the change in tax structure, we wonder if most surgeons aren't abandoning the percentage basis and charging flat rates. Can you enlighten us about this trend?"

Several hundred times a month, our reader's service staff grapples with practice-connected queries like this one. And, as a rule, it manages to come up with helpful answers. (In the case cited, tear sheets of our past editorial, "Toward Standardized Fees," provided all the enlightenment needed.)

Other times, the questions are such personal ones, or so tied up with local conditions, that the best answer from us can be of only limited help. This was the case just recently, when a Florida medical leader wrote:

"Our hospital has installed a beauty-shop service, and several of our staff OB men favor the idea of

presenting their patients with free hair-dos. Will you please let me have your opinion on the ethics of giving such presents?"

Regrettably, we couldn't produce the desired dictum on hair-dos. But we do have pretty good luck with the major subjects in our field. The ones we're asked questions about most frequently are office planning, income-tax deductions, practice management, legal matters, fee setting, insurance, and investments.

A few queries recur again and again. In recent months, for example, our incoming mail has been full of the following:

¶ "What can you tell me about investing in mutual funds?"

¶ "Where can I get good malpractice insurance?"

¶ "What's the best financial arrangement when one doctor takes over the practice of another?"

Oft-repeated queries usually lead to full-length articles in MEDICAL ECONOMICS (they did in the examples mentioned). But what if the query isn't quite that important? And what if the answer is still of interest to many M.D.'s?

Perhaps you've noticed our new Questions department (page 75, this issue). It's designed for queries of just that type.

Got one yourself? Then send it along. With thousands each year to choose from, we'll still welcome your question. It may prove of such wide interest that we'll want to answer it in print. —LANSING CHAPMAN

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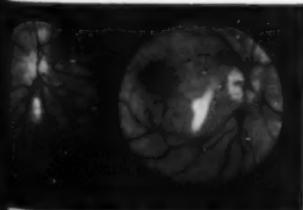
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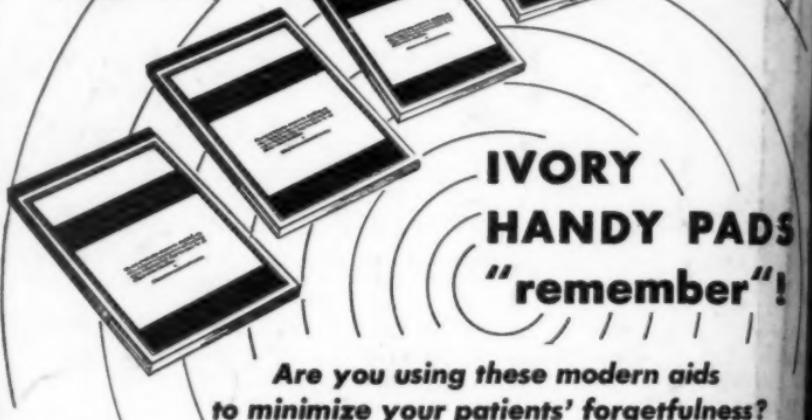
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1. Krantz, J.C., Jr. & Carr, C.J.: The Pharmacological Principles of Medical Practice, The Williams & Wilkins Co., Baltimore, Md., 1951, p. 836.

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